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WE ARE here to do honor to Frankwood Williams, the man, the teacher, the mental-hygienist, and the great humanitarian.

These remarks of mine are made in a reminiscent mood, recalling many details of long years of association. My first contacts with Frankwood Williams were in 1913, when he, as executive director of the Boston Psychopathic, sat through the long, tedious staff conferences in which we all, as clinical psychiatrists, struggled with routine diagnoses and the disposition of cases for permanent institutional placement.

It was at this time that I first became aware of his unusual vision and dynamic interest in this field of early mental hygiene. His outstanding capacity for deeper and broader penetration into human and social problems was the more striking because the concern among the staff group was for the most part avowedly diagnostic. You know that in that period the Kraepelinian classification method was, to say the least, overworked, and little concern was evidenced as to the causation of the illnesses or the mental-hygiene implications of prevention.

In our many talks I found him restive; he felt burdened by the dogmatism and self-satisfied attitudes exemplified in the effort of the group to achieve the perfect diagnosis of end results. His native curiosity and eager enthusiasm drove him forward into ever-broadening inquiries into the cause-and-effect relationships of mental illnesses. This eagerness

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impelled him into further investigation of the social and environmental elements lying behind the personality problems with which he dealt.

Humanitarian that he was, his move from the circumscribed area of the psychopathic wards to the broader fields of educational and social psychiatry was a logical step in his early scientific progression.

In the early days, as director of the Massachusetts Society for Mental Hygiene, he injected a new and significant emphasis into the state-wide educational efforts in this field. He believed fundamentally in the dynamic values of mental hygiene. He conceived of mental hygiene not only as a branch of medicine, but as a medium through which a rule for better living might be acquired.

Early in this period he became seriously concerned with the inadequacy of the psychiatric instruction given to medical students. He expressed this concern practically by collecting catalogues from every medical school in the country. One day he presented me with the whole lot, a package weighing fifty pounds or more. The specific request that went with this gift was that an accurate picture be furnished him of the hours of psychiatric instruction—and he wished that a detailed comparative chart be drawn indicating the hours of instruction in theory and of clinical experience offered in each training center.

The sad results shown by this study furnished him with an even greater urge toward stimulating psychiatric education for the student groups. The impetus toward better psychiatric education, given by him, has continued to extend itself. The active educational committee under the auspices of The National Committee for Mental Hygiene is a direct outgrowth of his efforts. That there is still much room for further elaboration of the subject matter of social psychiatry in the general field of clinical medicine, no one can deny, but he felt real gratification at the very significant effort made by many schools to increase their facilities for training. His active participation in organizing a mental-hygiene program for college students in a number of universities is well-known, and this work, too, has slowly been extended to include a greater number of students.

Although a peace-loving person, the psychiatric problems

precipitated by the vast war machine which engulfed us in the first World War gripped his attention and impelled him into service. As chief of the Division of Neurology and Psychiatry, the contribution that he made to our better understanding of the emotional difficulties precipitated in our boys through conflicts of aggression is also well-known. He did an outstanding job and was proud of this record of service, although his poignant sense of the useless waste of good human material was always a source of deep regret to him, for such destructive waste was diametrically opposed to his belief in the dynamic value of mental hygiene as a preventive tool for social growth and progress. As co-editor of *Neuropsychiatry,* Volume X of the *Medical Department of the United States Army in the World War,* he contributed vastly to the adequacy of this important work.

When in 1917 he joined the staff of The National Committee for Mental Hygiene as assistant medical director, he found a new and broader medium for extending his social and educational interests. Largely through his efforts, the quarterly, MENTAL HYGIENE, became the outstanding nation-wide publication in this field. As editor, he stimulated younger psychiatrists in their ventures to express their views. Many can attest to his painstaking endeavor to bring universal meaning out of the earlier contributions of the beginner. He was never too busy to give a helping hand, and hours of personal thought and encouragement were a part of his routine day of work. One of his keenest pleasures came from seeing the younger men and women achieve self-realization.

The assumption of the additional task of instructor in social psychiatry at the Smith School of Social Work each summer gave him further satisfaction and added to his already real interest in the field of social work. That too frequently this summer teaching was taken on as a pleasure exertion, in lieu of a real vacation, never perturbed him in the least. He found the eager-minded response of the social-work group provocative and fundamentally satisfying.

So often in our discussion of situations met in the field of social work he expressed his real identification with the group as a whole. He believed in social workers. He recognized the kind of service that a well-trained worker could render in her endeavor to assist the under-privileged to a more adequate

integration through a solution of some of their conflicts. He saw in this group of workers the potential material out of which a better organization of preventive work might be molded. He knew the importance of a very adequate personality adjustment for each worker and through his analytic therapy aided many to acquire more complete personal integration.

Even after pressure of work had forced his withdrawal from the Smith School, his interest in the education of social workers expressed itself in his contacts with the New York School, the New School for Social Research, and many other social-work groups.

His participation in group discussions and forums for educators and social workers was a part of his enthusiastic attempt to extend the social psychiatric contribution in its broadest sense.

After the resignation of the director of the National Committee, Dr. Thomas W. Salmon, more responsibility fell upon him whose schedule of work was already overcrowded. As medical director, he extended his already rich contribution in an ever-broadening area of mental hygiene, and for the next nine years his outstanding work in the national and international field greatly increased the prestige of this new science.

For months prior to the first International Congress of Mental Hygiene, held in May, 1930, Dr. Williams, as director of the program, was occupied with organizing and planning the very rich schedule of scientific papers which were given. Only the members of his collaborative staff know the vast extent of the labor and detail in which he was involved in the preparation of this outstanding series of meetings. When one realizes that he made contacts with psychiatrists from over fifty different countries, arranged for the preparation of all the papers, personally supervised details of transportation and the personal comfort of the delegates, organized a staff of translators so that prior to the meetings all papers were available in English as well as in the native language of the speaker, formulated a plan for the effective use of interpreters, and made himself personally available to any delegate who wished a conference, one can but marvel anew at this

man's outstanding capacity and at his fundamental unselfishness and ever present good nature.

In 1932, Dr. Williams, as editor of the Proceedings of the First International Congress on Mental Hygiene, brought out two large volumes which contain the complete scientific program.

When, in December, 1930, Dr. Williams decided, after due deliberation, to withdraw from his duties as medical director of The National Committee for Mental Hygiene, he left behind him an enviable record of outstanding service to the cause.

Withdrawal into private work in an analytic capacity made him available for a fine service to many individuals. The great number of persons whose lives have been enriched through his professional contribution attests to his outstanding ability as a therapist. I, who have been privileged to interview eleven of his patients since his passing, can only bow my head in deepest respect for his unusual capacity as a psychiatrist. Without exception, each and every one not only indicated an amazing ability to adjust to his loss, but expressed the feeling that they had derived sufficient help from their contacts while in his care to carry on and a readiness to accept another therapist to complete the work he had so well begun.

I wish it were possible to comment upon the many facets of Dr. Williams' broad interests. However, his interest in Russia is perhaps best known to you. I recall an occasion at the beginning of his exciting adventure into his study of this new social experiment.

After the First International Congress of Mental Hygiene in Washington, I spent a thrilling evening with the Russian delegate, the late Dr. L. Rosenstein and one of his associates, at Dr. Williams' home. Discussion was intensely interesting, particularly our attempts to find a common denominator in the mental-hygiene problems met with in Russia and in this country. The psychological reasons why delinquency did not exist for them as it did for us was obvious. Dr. Rosenstein's apparently casual acceptance of the fact that a million or more of the older generation might commit suicide or become psychotic as a reaction to the deep conflicts precipitated by the changing order of things shocked us deeply. It was start-

ling both to Dr. Williams and to me, steeped in our kind of social psychiatry.

I remember our thoughtful silence as we taxied up Fifth Avenue. Our whole perspective had been given a severe jolt. Finally I broke the silence and said, "This Russian attitude about human lives scares me to death. As mental-hygienists, we have spent years attempting to create a better integration of parent-child relationships. This evening we have had a glimpse into a psychological revolution. Of course there is no occasion for adolescent revolt. The new government has become the benign parent with whom the child can identify without conflict." To this Dr. Williams replied, "To be honest with you, I was scared, too, but we must study the implications of this social change more deeply." Later, one finds him reiterating this very point of view in his volume, *Russia, Youth, and the Present-Day World* in this thoughtful statement: "Will the present approach tend to solve the problem of high potential anxiety by bringing to a minimum those psychological factors within the growing child that lead to anxiety, or will a wholly new set of factors be created that may be no better than the old? Will a totally new condition be produced or will new problems merely replace the old ones?"

Knowing Frankwood Williams as we all did, one realizes his honest simplicity, and how perfectly he exemplified our ideal of a truly great mental-hygienist; as he lived and worked, so he wrote. The clarification of his own position found in the preface of *Russia, Youth, and the Present-Day World* exemplifies him so well. He says: "I am a physician. In the field of medicine my specialty is psychiatry. For the past twenty years, as physician and psychiatrist, I have been working in the field of human relations, which means the relationship of one individual to another, of the individual to the group and of the group to the individual. The problems one deals with have to do with marital, home, or domestic relationships, juvenile or adult delinquency, nervous and mental illness, the maladjusted child in the school or the home, the child-teacher and parent-child relationship, the emotional development of children and the special problems of adolescence. Broadly, this is called 'mental hygiene.'

"I have never been a 'radical.' In social matters I have been just an ordinary American citizen, interested mostly

in my own work, and so far as political or social matters were concerned inclined towards some sort of 'liberalism' . . . One does not make up one's mind all at once about the experiment in Russia. One is too shaken and there is too much to think about. At least, so I have found it. Gradually one's thoughts begin to take form. . . .

"If in the end I seem more sure than in the beginning it is because in two years some things seem clearer to me."

Exceedingly characteristic of his impulse always to objectify his own emotional responses and those of other humans are these words of his: "What are any of us doing but struggling along trying to find our way, and what more can we do than to exchange honestly our thoughts and experiences, to say to another as clearly as we can what really we do think, knowing full well that we may be wrong, but that we have been as right as we could be." This, in essence, was his philosophy.

"There are those who give little of the much which they have and they give it for recognition, and their hidden desire makes their gifts unwholesome. And there are those who have little, and give it all. These are the believers in life, and the bounty of life, and their coffer is never empty." In these words of the poet, the whole pattern of his life seems crystallized—for in this way lived our friend, Frankwood Williams.

THE SIGNIFICANCE OF PARENTAL RESPONSIBILITY *

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AT a moment when civilization seems to be experiencing a series of seismic shocks, we may well ask ourselves, "What is the true secret of social stability?" The answer might be given in some such words as these: "The cumulative ideals of the citizens and their individual capacity to express them." Some of you will say that, in the light of modern psychology, this is an old-fashioned conception! Perhaps it is; yet I feel progressively impressed by the fact that self-expression and mere adjustment to reality cannot provide the dynamic of a progressive society.

Accept for the time being my tentative formula. We have then to ask ourselves, "How are citizens to develop progressive ideals and the power to express them, and what have parents to do in the matter?"

Every human being is, of course, the product of two component sets of forces. These are often referred to as nature and nurture, or breeding and rearing, or eugenics and eutrophics. In this conference we have both parents and teachers, and therefore there are those who must be practically interested in both sides of the complex problem.

Let me begin by taking first the second factor, nurture, upbringing, education—call it what you will. Dr. Montessori has given us the slogan, "A new world for a new man," and that is an inspiring slogan. But it must not blind us to the fact that as we introduce new and progressive methods in education, the child is being robbed of old prerogatives and age-long conditions that had great value. The three great needs of the child are security, valuation, and freedom—in that order. It is vain to give freedom to the child that is unsure of its environment. It is useless to offer freedom to the unvalued child. Now you all know as well as I do, and probably better, how the Montessorian principles promote

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these three primary requisites. The child in a well run Montessori school feels perfect safety; he is aware of the affection of the teacher; he has perfect freedom. But after all most children spend only about one-sixteenth of their year in a school. For the rest—yes, for fifteen-sixteenths of their year —these children are directly or indirectly in charge of their parents. I do not need to stress to such an audience as this the lugubrious truth that all parents are not Montessori-minded. So we have already reached this result that during the years of Montessori schooling the opportunity of the parents is as 15 to 1 to that of the Montessori teacher, and you know very well that the years we are dealing with are the most formative years of the individual's whole life. This statement, without any addition, would almost justify the claim that parenthood is the greatest business in the world.

Every child demands three prerogatives — a father, a mother, and a home. These are the things that cannot be taken from it without a sense of injustice. Whether the fault be the parents', or society's, or God's, is immaterial to the child; the absence of any one of these three factors constitutes a grievance. The only boy may want a little sister, but her absence is a deprivation of a totally different order, because it does not affect the security of his background. Soldiers, sailors, civil servants, missionaries, and all whose vocations preclude the stable and normal home rear children under conditions that are more exacting than is generally supposed. And why? Because continuity of environment is the first condition of security to all young children. Now what are we to say of the homes that are broken, not by circumstance, but by folly or worse than folly? It is the children who suffer, because, in the first place, their security is undermined. And as I have said before, security is the first thing the child requires —apart from its mere animal requirements. The child with a sense of insecurity can only by a miracle of subsequent education develop into a poised adult. Self-defense infiltrates his being, and he grows up to manifest it in evasion and compensation.

Note, then, the normal order of events. The child begins in his mother's arms. There he has, or should have, the double sense of security and valuation. The sense of security must

be withdrawn by imperceptible stages so that as the spirit of adventure dawns, it shall always be commensurate to the withdrawal of security. I daresay some of you have heard of boys being "taught" to swim by the very simple process of taking them out in a boat and throwing them into the sea. That represents, in an exaggerated way, what we do whenever we withdraw security too suddenly and in advance of the spirit of adventure. I recall a boy who was kept in India as an only child till he was nearly fourteen. He was then brought to this country for the first time, entrusted to a widowed grandmother, and sent in a few weeks to one of our roughest public schools. The results were no more disastrous than one would have expected. The true spirit of adventure, which is the very vitamin of character, can develop only where the child has found that life in general is trustworthy. You see, then, how important is the responsibility of the parents in insuring a secure background for the child.

I have just said that in the mother's arms the child experiences both security and valuation. Now, this valuation is in its character unique at the beginning. One of the child's first lessons is to accept the fact that it is not unique—in other words, the child has to be weaned. But it is not always weaned. I could name quite a number of septuagenarians who were buried before they were weaned. By that I mean that they maintained to their dying day the conviction that they held a unique place in the affection and consideration of some mother-substitute, and that this was their prerogative. Generally they referred to the mother-substitute as God. Perhaps the greatest contribution which the Montessori school is making to this generation is the happy and effective weaning, in a spiritual sense, of a large number of only children. That is to say, they learn to share adult valuation without resentment. But, as you all know, there are parents who are more than capable of neutralizing this beneficent process, and of maintaining the morbid attitude of the unique valuation. The formula, which is apparently too difficult for many parents to accept, should be: "All children are important; you are no exception nor are you any sort of miracle."

Parents, then, have to steer between the two dangers of maintaining the sense of unique valuation on the one hand,

and, on the other, of giving a feeling of devaluation. Of course, there are parents who are ill-tempered, neglectful, impatient, mean, selfish, and so on. These faults are obvious. But they are not the worst. Whenever a child feels abandoned, it interprets the experience as being due to parental devaluation. When the missionary's wife says to her five-year-old son, "I am going back to China with Daddy, and you are going to stay here with Aunt Susan, and you'll go to that lovely little school, and I'll write to you every week," etc., it matters not whether the mother is going for love of Daddy or China or God, the five-year-old can interpret this only as a threat to his security and an act of deliberate devaluation. "If Mummy loved me as much as she says she does, she would stay here." When I think of the thousands of abandoned children—not all in the class of "Baa, baa, blacksheep"—who have suffered from this irrational, but natural feeling of parental devaluation, I realize that the price of Empire is largely paid by the children.

Business is another form of maternal devaluation. I remember a schoolboy thief whose mother was a paid political organizer. He said, "We always used to feel that Mother put politics before us." I remember an only boy who was brought to me for a number of nervous manifestations. His mother was a hard-hunting woman. He once said to me: "I was always afraid of Mother ticking me off for disturbing one of her dogs."

A short time ago a private soldier committed suicide at the age of twenty-three. I had seen him when he was fifteen. He was left in the waiting-room while a very omnipotent mother flounced into my consulting room and made the following remarks, almost before she had time to sit down! "Well, you're my last hope. Have you got a lethal chamber for boys? I would give any one a shilling to take George away for good." Well, it took eight years for George to find the lethal chamber, but I cannot help thinking that a modicum of mother love might have altered his story.

We all know the very common tragedy of devaluation on account of sex. What school—Montessorian or otherwise—can make a man of the fourth son with no sisters, who says, "I never remember the time when I didn't know that I was a

great disappointment to Mother because she wanted a girl so badly." And again, "I know that she refused to look at me for a week after I was born because she was so heartbroken." Nothing can obviate a feminine development of that boy's character; no one can share the responsibility with the mother, and only she can right the wrong she has done. Or again, take the tragic cases that might have been avoided. A woman of thirty-six began to show suspicions toward most of her fellow workers in her office. When I first saw her, I recognized that she was hopelessly delusional. I warned the relatives that to prevent her committing suicide she must be put under restraint at once. This they refused to do, chiefly because her grown-up nieces might have had less chance of marrying. The inevitable occurred in a few months. Now, what had her history been? Always aloof, truculent toward authority, mistrustful, she had sought valuation in the most unsuitable form of love interest. The first time I saw her, she said to me, "I always knew I had been an accident. They couldn't have wanted a ninth child after eight years, nor a sixth girl when they had only three boys." A large proportion of the people who wish they had never been born are merely echoing the sentiments of their parents, and protesting against parental irresponsibility.

But of all forms of devaluation the worst is the broken home. A highly intelligent schoolboy of fourteen writes to his father: "Mummy told me on Sunday that she was going to divorce you. Daddy, for God's sake write and tell me it isn't true. I don't know how I'll bear it. I shall never be happy again—nor will Pam and Chris. And it will be in the papers, and all the fellows here will know, and I shall feel like running away. The boys here all say that X.Y. must be a rotter because his parents had a divorce. Your heartbroken Son, Michael." That twig has duly been bent, not to mention Pam and Chris, nor the great array of wards in Chancery who have good reason to know that their parents did not value their children sufficiently to put up with each other.

One of the wisest head mistresses I know said that one out of three of her girls comes from a broken home, and that that third is responsible for 90 per cent of the disciplinary trouble throughout the school. I am disposed to accept these figures. The whole problem assumes the aspect of a vicious circle. The more cases that go to the divorce court, the more lenient does

public opinion become. The more marriage is looked upon as a terminable contract, the more irresponsibly will it be entered upon. And the phenomenon which one may surmise would astonish a Martian visitor is that a parent, or two parents, who have shewn such complete irresponsibility toward the next generation are allowed to go their way and not only marry again, but produce more children to be treated with an equal lack of responsibility. And then people raise loud protests against a bill for voluntary sterilization. Perhaps some day there will arise a lawgiver who, in the name of the children, will suggest some treatment, such as compulsory sterilization, for the irresponsibles who have failed in their parental stewardship. Our courts of justice deal in damages and alimony, but the damages that are beyond all human assessment are those that the children suffer, and these are damages that neither will nor ever can be paid. One could wish that as we have tests nowadays for accident-proneness in motor driving, and tests for aviation, so we might develop some form of test for responsibility in social conduct. We might then grade candidates for marriage in some such pleasing way as this: 50 per cent of possible marks to pass for marriage; 80 per cent to qualify for parenthood. You say that our birth rate would go down; so it would numerically, but the quality would more than compensate! However, I hope that none of you is taking me too literally, for I am talking now only as a speculative psychologist and not as a practical or a very serious person.

We have seen that the child is entitled to security and valuation. He is also entitled to freedom. Fortunately, I need no more than mention this point, for there could be no audience, I imagine, more alive to the necessity for freedom. But let us please have sane freedom and not the kind that excludes adult interference to such a degree as to expose unfortunate and unpopular children to the grossest persecution by a tyrannical majority. Nor must it be that insensate caricature of freedom that prevents a child from developing any self-discipline. All Montessori teachers have had experience of those sentimental and weak-brained parents who promote a freedom that can never lead anywhere but to ineradicable self-indulgence. There is only one crucial test of freedom in education. It is this: "Does the freedom that the child is experiencing keep him in love with growing-up?"

There are a lot of modern parents to-day who interpret freedom for themselves in terms of irresponsibility. Psychologically, they have never grown up. In so far as they give freedom to their children, the result will be the same—it will be interpreted as freedom to be dependent and irresponsible like the parents. And you teachers know this very well. But you would not be popular if you printed on your school stationery: "Parents, remember that character teaches over your heads."

And so is the educational chain completed: the parents who are psychologically mature give their children a freedom that stimulates them to grow up. Citizens who have grown up in freedom are fit to govern themselves in a free community. But the insecure, the unvalued, the unweaned, the irresponsible are fit only to be ruled by the tyrant or the demagogue; it matters little by which.

I have said enough—perhaps too much—of the responsibility of parents in the nurture of their children. Let us now turn to the genetic side. It was C. E. Montague who gave us the most perfect formula for eugenics: "The august and precarious stewardship of the clean blood of the race."

During the war we woke up to realize that we were far from being an A1 people. Since that time we have advanced quite a lot in matters of environment and nutrition, but what progress can we show in eugenics? The simple principle by which every stock-breeder abides is that of breeding predominately from the above-par section of his herd. He knows well enough that he cannot otherwise hope to keep up—let alone improve—the quality of his herd. Below the level of man and the domesticated animals, nature takes care that a species becomes extinct if circumstances permit of its breeding from the less fit. The plain and incontrovertible fact is that our birth rate is going down—in itself perhaps a good thing, perhaps not; that is a matter of opinion. But what is alarming is that the birth rate of the above-par is shrinking faster than that of the below-par. And from that disconcerting fact we must deduce that man is not yet awake to the "august and precarious stewardship" of which I have spoken. True, children are not being born by accident on anything like the scale that obtained before the war. Modern contraceptive methods have made conception and child-bearing much

less haphazard. But what are the effective considerations? Chiefly economic and self-interested.

Man has still to learn that his unique position in nature turns on the fact that he, and only he, can be a purposive coöperator in the evolutionary process. No other animal can exercise the choice that controls instinctive behavior. Therefore, it is man alone who can shape the genetic future of his species.

A short time ago I said something of this sort in a lecture addressed to a group of doctors. One young man, asking a question after the lecture, said: "After all, why should we be interested in the future of the race?" I believe there are thousands of young men and women in our land to-day who would have applauded that question. To me it is sheer paganism. It is the repudiation of the whole concept of the onward march of humanity. Humanity has advanced—some think a long way, others differ; in any case it has advanced since the dawn of history. And it has advanced without any clear idea of genetic responsibility. But that was simply because up till a generation ago breeding, with man, was to all intents and purposes as instinctive a procedure as it is with the animals. But one generation has sufficed to bring about a remarkable change in civilized countries. Material contrivances have made it possible for man to gratify his instinctive desires without the necessity of procreation. The result is that man's contribution to the future of his race is largely a deliberate affair, a satisfaction of the parental urge, an act of service to an ideal, or perhaps a concession to conventional and superficial demands. Therefore, the "august stewardship" stands or falls not by biological impulses, but by social values. This challenging alteration in race conservation has already produced notable repercussions in politics. We have first of all Russia, where every effort was made to substitute promiscuity for permanent marriage and state rearing for family life. But it did not work, and if there is a grain of truth in what I have been saying this morning, there was no reason why it should work. A complete change has taken place in official policy and now we are told that the stability of the family is to be regarded as necessary to the development of the state.

Then in the dictator countries we have a premium attached

to eugenic motherhood with a variety of stimulating or coercive measures. The dictators are shrewd enough to recognize that, left to himself, modern man is not big enough to fulfill the "stewardship of the clean blood of the race." Left to himself, as he is in a free and democratic country, he cannot be trusted to refrain from propagating the unfit or to accept the burden of propagating the fit in sufficient measure. Hence the dictators predict with considerable assurance that democracy can be left to exterminate itself, because in a democratic country dysgenic breeding prevails, whereas only among a "disciplined" people can a eugenic standard be maintained. This to most of us is a depressing reflection. Must we accept it as valid? For my own part I cherish a vision of a community that is sufficiently enlightened to know what the future welfare of the race demands; of men and women who will choose their mates with a due sense of genetic responsibility; of individuals sufficiently controlled to face the frustration of the parental urge where the stock is below par; of parents to whom an adequate and worthy stake in the future is the most satisfying form of contribution to human progress. But unless this sense of racial stewardship attains a religious value, democratic man will continue to exercise his freedom, political and biological, by subordinating the interests of the race to self-interest and the claims of the future to the more insistent claims of the present. Are we to accept the depressing conclusion that modern conditions of life have become too competitive to leave room for voluntary contribution? Or is man becoming such a materialist that the spiritual satisfactions of parenthood are losing their appeal? Or, peradventure, is his adherence to the herd so cynically shallow that he cares not what becomes of it after he has ceased to need its protection?

I offer no answer. I can only say that for me it matters whether the human race, and particularly my section of it, is moving further from the ape or reverting to its level; whether it is approximating or retreating from the divine. And the feeling that I have contributed, even in the most fractional degree, to the possibility of human progress is the only condition that permits me to reflect with any degree of composure on the "unmerited mercies" of nature and nurture that have fallen to my lot.

WHAT IS THE PLACE OF MENTAL HYGIENE IN SOCIAL WORK? *

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THERE are two schools of intransigent opinion which would dispose of the question presented in my title in three short, crisp monosyllables: "It has none." This is the position, in theory at least, of those medical practitioners who still think of their art in terms of the scientific materialism of the nineteenth century. Their standpoint in psychiatry was expressed by Dr. Lewis Bruce in his *Studies in Clinical Psychiatry* nearly thirty years ago:[1]

> "When psychology is divorced from psychiatry, and the study of psychiatry is prosecuted along the lines of advance in general medicine, our knowledge of mental diseases cannot fail to be added to. The matter contained in the following pages is based on work so conducted; psychology is omitted. . . ."

From this point of view, psychiatry is still "mental medicine" in the orthodox sense of the term; its basic sciences are biological, not social; its therapeutic measures are those suggested by neurology, physiology, anatomy, histology, chemistry, not those derived from psychology, sociology, economics. It is believed that all the problems of man in society are ultimately explicable in biological terms; that all differences, whether of the individual or of the group, whether of personality or of social organization, are due, not to tradition and culture, but to hereditary and constitutional factors. Consequently, the social sciences are at best a body of common-sense ad interim knowledge, part of which is on its way to becoming scientific through being biologized, while the remainder is being sloughed off as superstition and folklore.

Manifestly, to one who maintains a consistent theory of

* Revised from a paper read at the Tennessee State Conference of Social Work, Knoxville, March 24, 1936.

[1] Quoted by Bernard Hart in *Psychology and Psychiatry.* MENTAL HYGIENE, Vol. 16, April, 1932. p. 178.

biochemical determinism in psychiatry, mental hygiene has no place in social work. Nevertheless, even from this standpoint, social work does have a place in psychiatry. The psychiatrist may believe that social work in the long run does more harm than good by coddling the unfit who, in a ruder state of society, would be ruthlessly eliminated in the struggle for existence, but he cannot entirely dispense with it for all that. For after all his patients do come to him from their setting in the social world. And after he has treated all the pathological processes he can discover in the organism—infection, intoxication, endocrinological and metabolic disturbances, and the like—many of his patients will return again to the social world from which they came. The more firmly he believes that his treatment is powerless to remove the constitutional inadequacies responsible for the original trouble, the more dependent he is upon the social worker for the manipulation of the environment in such a way as to enable his patients to live within the limitations of their inadequacies. Occupation, family responsibilities, type of housing, location of residence, any or all of these may need to be changed to protect the patient against undue strain. This may in turn require temporary or permanent supplementation of income, brief or prolonged supervision until the patient has satisfactorily adjusted to his new mode of life, and so on. In short, it may be necessary to bring into play all the resources of case-work and group work as well in order to conserve the gains which the patient has made under treatment. But the rôle of social work remains subordinate. The sociogenic and psychogenic factors in mental maladjustment and personality disorders are incidental and superficial. Genuine causal efficacy resides in the biogenic factors alone. Research in psychiatry is confined to their investigation, therapy to their correction, prevention to their elimination. From this point of view, mental hygiene, conceived of as psychiatry applied to the field of prevention, has less to hope from the social control of the environment than from the eugenical control of the germ plasm.

Now, all persons who are seriously concerned with the scientific study of man, whether as a disparate organism or as a member of society, insist upon having all the light that

the physical and biological sciences can throw upon the constitution of the human organism and its reactions. But in increasing numbers they deny that these sciences set the limits to our knowledge of causation or to our resources for treatment. They admit that all social and psychological processes have their physical correlates in the nervous system, but they reject the dogma that all causation is from the physical to the psychological and the social, and that treatment involves the control of the psychological and social through the physical, seldom or never the reserve. Accumulating evidence within the biological field itself renders this dogma no longer tenable. The studies of the Brush Foundation in Cleveland, for example, have demonstrated that disturbances of the child's sociological relationships may not only result in functional disorders in thought, feeling, and overt behavior, but may also produce permanent abnormalities in skeletal growth. In summarizing his studies of such abnormalities made with X-rays upon the bones of living children, Dr. T. Wingate Todd[1] writes that physical ill-health "is not the only factor that can make its imprint on the growth record. Here is Ruth, now three and a half, living with her mother, a woman of courage and spirit. Ruth's nutrition is good . . . But in her bones she carries the scar of some deep wound occurring when she was two years old. And this is what we learn . . . When Ruth was two years old, her father deserted . . . and has not been seen since. The resulting domestic confusion marked the very body of the child . . . If we did not see it in case after case we could scarcely believe that sickness of the spirit could leave so clear a trail."

But if sociogenic causes "could leave so clear a trail" upon the skeletal structure of the child, on what grounds shall we deny their efficacy in leaving an equally clear trail upon the structure of the personality?

Such is the point of view that underlies the recent rapid advances in social psychiatry. It grants full recognition to all the biological sciences, and to medicine as a fundamental healing art. Constitutional factors, whether hereditary in character or acquired in the processes of physical growth,

[1] See "The Telltale Skeleton," by T. Wingate Todd, M.D. *The Survey Graphic*, Vol. 66, April 1, 1931. pp. 14f.

condition the functions of the personality in its social adjustments. In many cases the constitutional basis is so inadequate that difficulties in adjustment are inevitable. In such cases, individual life experiences may determine the content of the psychosis or neurosis, but the possibility of a future successful adjustment will depend upon the successful treatment of the constitutional factors and physiological processes involved. But even these cases disclose "certain ever returning tendencies and situations" which, as Dr. Adolf Meyer has said,[1] "can be understood only in terms of plain and intelligible human relations and activities." From those cases which must be understood and treated largely, if not entirely, in terms of gross organic pathologies, such as neurosyphilis and cerebral arteriosclerosis, we pass by an unbroken series of gradations through disorders of behavior and personality which must be increasingly understood and treated in terms of "human relations and activities," until we reach that vague and uncertain zone that divides the "abnormal" from the "normal." Throughout this series there runs an increasing recognition of sociological factors in causation, and of the social worker as an active participant in treatment.

The second school of thought referred to above, which finds little if any place for mental hygiene in social work, exists among social workers themselves. From this point of view, social work is concerned with the objective social and economic situations and relationships of its clients. It has no right to interfere in their personalities, and it has no techniques for doing so. There are far too many social workers who feel, as Dr. George K. Pratt expresses it,[2] that "they must 'do something' to or for a client, and who think, unless they can, there is no use in listening to a story of distress." Some of them even believe it a violation of professional ethics to secure information from a client which is of no use in formulating plans to meet his objective economic and social needs.

It must be acknowledged that there is something to be said for this view. In so far as it is a reaction against the old

[1] See "Psychiatry and Life Problems," by Adolf Meyer, M.D., in *A Psychiatric Milestone. Bloomingdale Hospital Centenary, 1821–1921.* New York: The Society of the New York Hospital, 1921.

[2] *Morale: The Mental Hygiene of Unemployment,* by George K. Pratt, M.D. New York: The National Committee for Mental Hygiene, 1933. p. 52.

inquisitorial type of social work which endeavored to find out everything about a client in order to distinguish "worthy" from "unworthy" applicants, it is entirely justified. In so far as it is a protest against turning social work into amateur psychoanalysis, it is to be warmly commended. Mental hygiene is a relatively new and ill-defined movement, and new fads and crazes are constantly endeavoring to establish themselves within its ample limits. Any one familiar with the facts can easily parallel from his own experience this situation, reported by a competent observer:[1]

> "Judging from the records, a bunch of embryo psychiatrists and amateur psychologists is turned loose upon these families to try out their theories. They have 'majored' in social science, or, judging from the way they mix up their terms, they have only a smattering of Freud to recommend them, but they are enterprising souls and feel that they are eminently fitted to 'reconstruct' these families, less fortunate than themselves. . . . The Visitor . . . draws her clients out and inveigles them into discussing their affairs, *even to their most intimate marital relationships.* . . .
>
> "Some of the families I visited personally, and later read the records of their cases. In many homes I learned touching lessons of patience, courage, and faith, and of old-fashioned loyalty. But *according to the records* most of these clients were of 'low mentality,' had fixations and complexes, and were either 'schizophrenics' or paranoiacs. . . .
>
> "From the records also I learned that *religious sentiment of any kind* was a sign of 'low mentality.' *Faith and gratitude were fanatical.*"

Upon this the observer rightly comments:

> "By what authority, and on what basis? Years of study go into the making of a reliable psychiatrist, but these workers are told from the start that a 'social worker' recognizes instantly a psychopathic case, and apparently we are all psychopaths, 'exceptin' me and thee!'"

In view of current tendencies, it cannot be too strongly insisted that social work is not psychiatry, and neither can nor should become so. Indispensable to psychiatry as social work is proving itself to be, the fact remains that the diagnosis and treatment of personality disorders within the individual is not the social worker's job. Because of the importance of the constitutional factors in many types of personality disorders and of the possibility of their presence in any given case, psychiatry must remain a branch of medicine. It is probably true that in many of the psychiatric problems that

[1] Cited by Charles C. Stillman in "Responses of Social Work to Changing Conditions Affecting It." *Social Forces*, Vol. 13, May, 1935. p. 546.

appear among the clients of social work no medical treatment is indicated. It is certainly true that in many cases in which the client is trying to shift responsibility for emotional dependency to a physical basis it is definitely contraindicated. But the decision as to whether medical treatment is indicated, not indicated, or contraindicated is a medical decision, and responsibility for the decision is a physician's responsibility.

But even if we should admit, with some of the more radical exponents of the psychoanalytic school, that medical education is not essential for certain branches of psychiatry, the mastery of this technique requires more thorough training than most social workers can secure, demands more time for the individual case than most social workers can give, and is more expensive to administer than most communities can afford. The psychiatric social agency, therefore, by whatever name it may be known, must continue to administer treatment under the supervision of persons medically trained, but it must also utilize all the other resources of the community, both medical and social, for diagnosis and treatment. The position of the social worker in such an agency should be precisely analogous to the position of the physician or clinical psychologist. All are specialists, competent to make certain contributions to diagnosis, and to assume active responsibility for certain rôles in treatment.

Thus far we have found a definite and important place for social work in mental hygiene. But can we find an equally important place for mental hygiene in social work? It is here maintained that we can. But it is unfortunate that in their endeavor to give it a place, many social workers are narrowing their conception of social work unduly, and are coming to think of it as being concerned chiefly, if not exclusively, with the emotional problems of persons in distress. From this point of view, all social maladjustment is emotional maladjustment, and the client's real problem is the affective one that is disclosed in the give-and-take between worker and client. The objective of case-work is not to understand the client's past history and present situation in order to "do something for him," but to manipulate the relationship with the client in such a way as to bring about an emotional development that will set him free to deal with his own problem.

This point of view tends to employ psychological rather than sociological concepts in the interpretation of case-work problems, and to rely upon the control of the worker-client relationship rather than upon the manipulation of the environment for treatment.

The result is that social case-work tends to become too narrowly absorbed in the client's inner life.[1] But its field cannot be so circumscribed. Indispensable as it is for the case-worker to become aware of the dynamics of the worker-client relationship and of its profound therapeutic potentialities, the problems of case-work cover a vastly wider range. Inner stress precipitates many problems of social maladjustment, but so does outer strain. Sometimes the forces of external nature—drought, flood, fire, earthquake—come crashing through man's feeble defenses and play havoc with his little world. Sometimes his own physical organism is impaired through contagious or degenerative disease, through loss of limb or sight or hearing, in such a way as to reduce his power of adjustment without social aid. Sometimes his own culture turns upon him like a Frankenstein and destroys him with depression, unemployment, war, revolution, mobs, riots, strikes. None of these are emotional problems of individuals, although they have their emotional implications. None of them are due to inner stress, although they may create it on a vast scale.

Let us define the place of mental hygiene in social work by inquiring what it has to contribute to the worker operating in this comprehensive setting of problems created by inner stress and outer strain, not by narrowing the field to analysis and control of what appears in the development of the worker-client relationship.

Mental hygiene should be a part of the professional training of every social worker to enable her to do intelligently and skillfully what she must otherwise do blindly and bunglingly. The adjustments of persons to one another within the framework of social institutions according to culturally sanctioned patterns are fraught with mental-hygiene implications, and

[1] This seems to be the case even in so challenging and indispensable a volume as Virginia P. Robinson's *A Changing Psychology in Social Case Work*. Chapel Hill: University of North Carolina Press, 1930.

their handling is a fine creative art. It has been practiced successfully for centuries by ministers, teachers, and parents who had nothing but the keenness of their intuitions and the sensitiveness of their perceptions to guide them. Mental hygiene promises to supplement these inestimable, but uncertain qualities with the surer insights of science in the interest of more adequate control.

But the most valuable insight of science is knowledge of our own limitations. Those of us who have come by the hard road of years of study of the sciences and of months spent in didactic psychoanalysis and who are yet so uncertain of our own motives cannot but marvel at the confidence with which the case-worker, Miss Fix-it-all, working under her supervisor, Miss Know-it-all, can trace the reactions of her client, Mr. Want-it-all, to an Œdipus complex or to a fixation at the narcissistic stage! If only we would stop to practice our techniques upon ourselves, our families, and our staff associates, we would understand better why we often fail to win coöperation and arouse opposition, why our efforts to create social harmony frequently precipitate a dog fight!

One is reminded in this connection of Dr. Abraham Myerson's confession:

> "Years ago I used to give a lecture which I called A Decalogue for Parents, that pleased both myself and the poor creatures seeking help. Our first child came—our second child came—and I changed the title of my talk to Ten Hints for Parents. Gone was the positiveness, gone the authority. Our third child came—and I stopped giving the lecture."[1]

Competent training in mental hygiene should first teach the social worker how to keep hands off wisely. Fortunately, human protoplasm has remarkable recuperative powers. Each of us has sprung from an ancestry that goes back to the dawn of man, every individual link of which was strong enough to survive the most destructive conditions with which existence ever confronted it until it could pass on the torch of life to other hands. Were it not so, we should not be here to comment on the fact. Fortunately, too, the drive toward integration and stability has been great enough in each of us to overcome all obstacles to personality development with

[1] *Sanity in Mental Hygiene*, by Abraham Myerson, M.D. MENTAL HYGIENE, Vol. 17, April, 1933. p. 218.

some degree of unity and poise. Were it not so, we should be holding this institute in a prison or a madhouse. Often the soundest hygiene for both body and mind is to stand aside and give the recuperative powers of nature a chance. The social worker must understand that unwise treatment administered to either body or personality may precipitate the very evils it would avoid.

But this does not mean that the social worker is assuming no responsibility, making no decisions, and administering no techniques in the field of mental hygiene. The competent social worker who "keeps hands off wisely" as a matter of conscious choice and not as a counsel of cowardice is employing mental-hygiene insights of a high order. The following case will illustrate the point:[1]

> "A prominent Hollywood professional man was obliged to apply for assistance for himself, his wife, and his sixteen-year-old daughter, a junior in high school. The father was in poor health and unable to collect fees owed him. At the time of the first visit, the proud parents informed the visitor that their daughter was an honor student and said by her teachers to be one of the outstanding pupils. Six months later, the daughter's work was in a precarious state. She was failing in one subject and just passing in two others. The financial condition of the family had so upset her that it was impossible for her to study or to concentrate on anything. The child lost weight and became extremely nervous. The mother secured work in the wardrobe department of one of the motion-picture studios and was able to assume the family support. Immediately the daughter's health and school work showed improvement."

This case might have been handled in much the same way as a matter of routine by an untrained worker without mental-hygiene orientation. But if so, the outcome would have been a matter of luck, not art. The contribution of mental hygiene consists in the worker's awareness that in this, as in millions of other cases precipitated by the depression, the emotional stresses are a *result* of social dislocation, not a *cause*. How does the social worker know that finding a job for the mother will relieve the daughter's tension? This may be obvious to common sense, but it is not so to science. For unfortunately all persons do not attach the same values to the same things. If the emotional attitudes of the girl are such that having a working mother is evaluated as a greater threat to her social

[1] Cited by Bessie Averne McClenahan in "The Child of the Relief Agency." *Social Forces*, Vol. 17, May, 1935. p. 561.

status than receiving relief, her emotional tensions will be increased by this solution. For the reaction of the client depends, not only upon the external factor of the social situation, but also upon the inner attitudes of the client's personality, and what these attitudes are only the client himself can disclose. Mental hygiene employs systematically and consciously the intuitions expressed by Shakespeare:[1]

> "There is a history in all men's lives,
> Figuring the nature of the times deceased;
> The which observed, a man may prophesy,
> With a near aim, of the main chance of things
> As yet not come to life; which in their seeds
> And weak beginnings lie intreasured.
> Such things become the hatch and brood of time."

The social worker who is conscious of her mental-health responsibilities will not act randomly, on the basis of routine. She will skillfully control the worker-client relationship in such a way that her clients will spontaneously reveal how this history functions in the present in determining their attitudes and in conditioning their reactions. If she is successful, she will be in a position to predict "with a near aim, of the main chance of things," whether the daughter's state will be relieved or aggravated by finding a job for the mother. In the latter event, circumstances may compel her to find a job for the mother anyway, but if she does, she will recognize the further obligations of case-work to the daughter. She will discharge this obligation with a view to attaining the case-worker's objective of social adjustment, without invading the psychiatrist's field of dealing directly with the difficulties within the personality. She will be aware of the hazards besetting the case-worker who ventures upon the latter course.

In the first place, she will hesitate to apply to this girl such terms as "emotionally immature," "dependent personality," or other psychiatric labels, in a pathological sense. It is true that the girl's emotional state is preventing her from dealing realistically with the situation, but if this be emotional immaturity, few of us are emotionally mature. The freer we are from inner stress, the more resistant we are to outer strain, but few of us can face a serious threat to our status without a more or less severe emotional upheaval. Rational

[1] *Henry IV*, Act iii, Scene 7.

comprehension of the new situation may come quickly, but emotional acceptance is a difficult achievement. Nowhere perhaps, outside of Oliver Warbucks in Harold Gray's comic strip, do men meet sudden reversal of fortune with clear logic.

Secondly, the competent social worker will avoid the psychiatrist's field because she knows that unskillful probing of the emotional life may precipitate worse conflicts, and the attempt to give insight in terms of psychiatric concepts may result in one of those tragedies of human suffering sometimes seen in those who have been unsuccessfully or unskillfully psychoanalyzed. Competency in such techniques of mental exploration and interpretation requires years of training in psychiatry and further years of clinical experience such as few social workers can possess.

Thirdly, mental-hygiene orientation will provide the social worker with some awareness of the uses and limitations of persuasion. If the emotional problem is superficial, the worker may persuade the daughter to accept the worker's view of the working-mother situation, but if it is deep-seated, no such persuasion will suffice. On the contrary, many adverse reactions may result from this effort. She may reject the worker's view intellectually because it is unacceptable emotionally, and thus not only destroy the worker-client relationship, but also be driven further into social isolation. Or she may accept the worker's view as reasonable, but, because she cannot also accept it emotionally, she may become the victim of increasing feelings of anxiety, fear, inferiority, guilt, or hostility toward herself. It is a psychiatric commonplace that rational insight without emotional acceptance may result in an increase of confusion, disgust, and impotence. For this reason, many patients show an aggravation of symptoms in the early stages of treatment, before any improvement is noticeable.

But mental hygiene has more to offer than these negative counsels. The worker employing mental-hygiene procedures in this case will assume active responsibility for developing the client-worker relationship so that the daughter will freely reveal her attitudes in the presence of the worker. This is necessary less in order that the client may understand the girl than that the girl may understand herself.

In all cases of emotional stress, the client's idea both of himself and of his situation is distorted by repressed feelings. As these find release in the neutral atmosphere created by the worker, his conception both of himself and of the situation undergoes change, and he is set free to deal with his own problem objectively. The client who enters the social agency denouncing the injustice of the economic order, the indifference of the government, the niggardliness of the relief allowance, and finally the inefficiency of the worker herself, may, if the worker does not meet his will with an opposing will which he feels must be either conquered or submitted to, return the next week with a matter-of-fact account of his difficulties which will furnish a basis for a practical attack upon his problem.

The worker with mental-hygiene training will endeavor in each case to answer the question, "What emotional significance does this individual attach to this experience?" Is the client who accepts the worker's plan without a word of protest a reasonable person with insight into the necessity of coöperation in a world sorely distressed, or is he transferring to the worker a feeling of dependence which has previously been manifested in other social relationships? Is the client who is surly and abusive expressing a fundamental trait of his personality, or is he a man who has been badly confused by a succession of catastrophes with which he has been unable to cope, and overwrought by the fact that for the first time in his life he finds himself incapable of independent self-direction?

Such a worker will also be free from the necessity of satisfying her own emotional needs through her clients. She will not be dependent on their gratitude or disturbed by their censure. These attitudes will be understood in terms of what they signify in the personal development and social adjustment of those who hold them, not in terms of the worker's own emotional life.

Nor will she permit her clients to satisfy their emotional needs through her. She cannot do this and remain the passionate partisan of their growth in security and self-direction. She must use encouragement and sympathy only in such a way as to render her clients independent of the need of them.

If on this account certain clients come to say of their case-worker, "I hate her. All I am to her is Case No. 11,206," it may indicate immaturity on the part of the client rather than incompetence on the part of the worker. She must withhold granting them the emotional security they desire to receive from her solicitous concern in order that she may not deprive them of their only opportunity to become secure in their own right. Her objectivity is not detachment, indifference, apathy, but genuine interest, penetrating understanding, sincere good will, quick responsiveness to her clients' groping efforts. She is, in fact, more than a friend in that in her self-control, and in her active endeavor to maintain the conditions essential to the development of personality, she goes far beyond what is required in ordinary human relationships.

Fortunately, the view here maintained is being taken as a matter of course by a constantly growing body of social case-workers. Over the portals of social work they have emblazoned the slogan: "Mental Hygiene, Welcome!" May the motto on the doormat be equally clear, "No Fads Admitted!"

AN ASPECT OF PASTORAL THEOLOGY *

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PASTORAL theology is that branch of practical theology which deals with the personal ministrations of the clergyman to his parishioners. This paper considers one aspect only, but a very important aspect, of pastoral theology.

The dean of one of our theological seminaries stated recently that he was concerned because the student body tended to split into two unrelated groups: one whose major interest was social, economic, and political reform, sometimes of a very radical character; and the other whose major interest was the priestly function, the ordered rendering of the church services and, more especially, the celebration of the Holy Communion.

Both these interests have their place in the ministry. I found myself in hearty accord with a recent ordination sermon which stated that the great opportunity of the clergyman lay in community leadership, although I think this leadership is more effective when it is exercised with wisdom and moderation. So also I believe whole-heartedly in the value of church services and especially of the Holy Communion. They are an important contribution to human well-being. Yet the clergyman is not only a community leader and a priest—he is also a pastor. And, as a pastor, he has a distinct, definite field of professional activities in which he can render services of the highest possible value, and in which no one of any other profession can adequately take his place.

As clergymen, we are concerned with the growth Godward of our people. The newborn baby, however much we may love him, is nevertheless essentially an animal. Life is the divinely given opportunity through which there may come into being an unseen, spiritual personality, of a strength, understanding, sympathy, and richness that are godlike in

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quality. At death, the animal body perishes, but we believe that the real self which has grown and developed through life lives on. Man lives well when out of life, with all its difficulties, failures, hardships, and tragedies, he somehow makes of himself a spiritual person in process of growing Godward.

But sometimes this development of the spiritual self is so blocked that it cannot go on unless the man is helped. These blockings are infinite in variety. Perhaps they are never quite the same for any two people. But it will help us to understand their nature by noting a few examples. Take the case of a boy who was an inveterate thief because a glandular maladjustment cursed him with a craving for breadstuffs. This boy was blocked in leading the good life by a purely physical abnormality. Often the way one *feels* about a physical abnormality, which of itself may be of slight importance, may be a blocking. A glandular condition causes a girl to be extraordinarily large and stout. No one loves a fat girl. She is ridiculed at school, ignored at dances. Since we must first be loved in order to love others, this unloved girl may be blocked from making a religious response to life and become resentful and bitter. Or one's emotional reactions to a facial disfigurement or to some permanent physical handicap may have similar results. It may be in no wise a man's fault that he is unemployed or that he fails in business, and yet because he is unemployed or has gone bankrupt, he may feel a false sense of shame which will block him in his desire to be a good husband and a wise and affectionate father. The one child of the family who is retarded mentally, who is ridiculed by his brothers and sisters, and who cannot compete successfully at school or in business, is very apt to be blocked by his feelings of inferiority. Since he finds it impossible to meet his life experiences in a way that makes for spiritual development, he resorts to temper, plays the bully, consorts with a gang in which he can play the rôle of leader, or perhaps withdraws from reality and lives in a world of daydream in which he can be Shakespeare or Napoleon.

One blocking in which the clergyman has an especial interest is guilt. This guilt may be due to actual wrongdoing—for example, an undiscovered theft or undiscovered extramarital relations. Or it may be more largely emotional in character

as, for example, guilt at having married against the will of a parent, even when the parent's command was unreasonable and arbitrary.

Let me emphasize that blockings are usually highly individual. Often they are so subtle that they cannot be described adequately except in a case record, and can be understood only by an intensive study of the person concerned. Very often they involve experiences of early childhood; patterns which have been built up gradually throughout life; emotional reactions to experiences which, although apparently unimportant, were crucial for the person involved; conflicts which sometimes go back into the deep recesses of the subconscious; and family interrelationships of the most delicate character. An infinite variety and complexity of blockings may prevent man from using the divinely given experiences of life constructively in creating a spiritual self; and it is the function of the pastor sometimes to smooth the road, but more often to enable the man who is blocked to climb over or to evade the blocking and to push on along the way of life.

This work is not entirely that of the clergyman, however. To a large extent, his function is to see that people are helped to overcome their blocking rather than to help them himself. Like all professional workers, he needs to have such a knowledge of other fields that he can refer people properly. The diagnostician knows just enough about diseases of the eye to refer the patient to the specialist, the oculist; he does not himself attempt to perform a delicate operation upon the retina. So the clergyman needs to know enough to realize that his parishioner should go to the physician or to the psychiatrist or to the analyst or to the social worker. If he is wise, he will know the limit of his own competence. There is nothing more absurd, or more harmful, than for the clergyman to be an amateur dabbler, say in psychiatry. Not only may he do serious injury to his parishioner through an attempt to be what he is not, but he justly exposes the ministry to the criticism that it is intruding into other fields because it has no field of its own.

But it very definitely has such a field. This is so closely related to one part of the field of social case-work that it can best be described by comparing the two.

At one time social work was engaged largely in social reform and in poor relief. In administering poor relief, it came to see how often a man could not earn his living because he was blocked by something of a physical, mental, or emotional nature. It became interested, therefore, in helping men to surmount or to evade these blockings in order that they might function more effectively. For a time, this interest in personality development threatened to obscure all other phases of social work. At present there is a better balance of interest between social legislation, poor relief, and personality development, but the latter continues to be very important. Theoretically, perhaps this work should have been done by the clergy. Perhaps, if they had been doing it, it would not have become a phase of social work. But the clergy were not—and, with important exceptions, still are not—doing it. And the skillful social worker, with a rich background of what science has discovered about human beings in their social relationships and of much fruitful experimentation in dealing with actual problems, has made a place for herself which the clergy may envy and supplement, but which they cannot, and should not if they could, usurp.

But however great the effectiveness of the social worker in enabling men to live the more abundant life, she does not and cannot cover the whole field, or even that part of the field which is not occupied by such specialists as the physician, the psychiatrist, and the analyst. If, to a considerable extent, she is now the only person in the field, it is not because she covers the whole of it, but because the clergyman has failed to occupy that part of it in which she does not function and he should. If this continues to be, human need may force her to come over and occupy our part of the field, and we shall have all our parishioners who have difficulties in leading the spiritual life going to consult the social worker or the psychologist, rather than their pastors. The clergy will then largely lose their pastoral function, which will be disastrous, not only for the clergy, but also for human well-being; for, although our parishioners who are conscious that something is wrong with them may secure adequate service, there will be no one to serve those who need help, but do not know it; no one to do important phases of the work which are preven-

tive; and no one who can use certain tools in treatment which the clergy alone possess.

Although the social worker is now, as a rule, the only person in the field, she still does not function to any great degree in that part of it which belongs to the clergyman. In even a very small parish, any one who has an eye to see and understand symptoms will observe many people who are blocked, wholly or partially, actually or incipiently, in their efforts to live the spiritual life; and few of these people have, or are apt to have, any contact with a social agency. Unless the clergyman serves them, either personally or by bringing them into contact with a specialist, no one else can or will.

It does not merely *happen* that this is so. There is a fundamental reason for it. Between the clergyman and his parishioners there exists, or should exist, a relationship which either cannot be established, or can be established only with great difficulty, between the parishioner and any one else. The relationship between a person who is blocked and one who would help the blocked person is a vitally important element in treatment. It is with those of his parishioners with whom the clergyman has a special relationship that he will find his field for effective pastoral work.

This relationship between the clergyman and his people must be distinguished carefully from mere formal membership in the parish. Formal membership in the parish does not in itself establish a relationship with the clergyman. The parishioner must know, trust, and believe in the clergyman before the relationship comes into being.

Even when the relationship exists, the clergyman must still decide what use to make of it. He may use it to help the parishioner accept the services of some other professional person better equipped to meet the special problem involved. He may decide that the parishioner can be better helped by the utilization of some relationship other than that with the clergyman himself. Suppose, for example, he suspects that some parishioner is blocked by a feeling of guilt in connection with his family life. But this parishioner is an active and a trusted vestryman. During any treatment process, it will be a great source of strength to him to feel himself trusted unquestioningly by the clergyman. The latter will, therefore,

use his relationship wisely if he has the parishioner accept the services of some skillful social worker, and through her obtain release from his guilt, while all the time he is strengthened by an unaltered relationship with the clergyman.

If a parenthesis may be pardoned, it is for reasons such as this that a social worker sometimes does not bring a parishioner's problem to the attention of the clergyman; and it is a tribute to the latter's own skill and insight if he does not wish her to do so.

In very many cases, however, the clergyman will perceive that the relationship which he has with the parishioner makes him the one person who can help effectively. He will feel very humble about his own skill. He will feel deeply the responsibility of serving as a physician of the soul. But he will see also that the spiritual life of the parishioner hangs on him and on him alone. This, then, is the field, the pastoral responsibility, of the clergy.

We shall now consider the tools which the clergyman has at his disposal for doing this work.

Two of these tools in treatment are also used by the social worker. One is relief. Its use as a tool in helping the parishioner overcome a blocking must be distinguished carefully from the giving of relief, usually by public agencies, to the unemployed, widows, and so on. Relief as a tool used in enhancing the capacity for living well is utilized sparingly and carefully by the social worker. The clergyman should be extremely cautious in employing it. He must always remember the high degree of ego satisfaction that one derives from dispensing alms, and the great danger that he is motivated rather by what is satisfying to himself than by what is helpful to his parishioner. It is remarkable how often, when a succession of clergymen have given alms to a man, it is to the clergyman who refuses to give that the man comes to talk about what is really blocking his life. There is also the other great danger that alms will break down the morale of the recipient and make him emotionally dependent, which is the very opposite of what the clergyman's purpose should be.

On the other hand, it is sometimes an extremely constructive thing for a man to be given such temporary economic

security that he will not have to worry over his finances, or that he may recover a status of importance to him emotionally. If the clergyman—after taking advice, if he is not very skillful—is sure that relief will be constructive, it should be given liberally, and in such a way that the recipient can exercise the greatest possible independence in planning a budget and making expenditures. Whether in such cases relief should come from the clergyman directly or through some other agency is a question that must be considered carefully in each individual case. If, as will be often the case, receiving relief from the church will make the relationship with the clergyman less constructive, obviously it should come through some other agency. But there will be cases where, for example, a man has been independent for many years, has been active in his parish membership, and has given generously to the parish funds—cases in which the parishioner can receive aid from the clergyman with less hurt emotionally than from any other source. The art of using relief effectively is extremely difficult, but the clergyman is making the right approach to it when he always considers with the greatest possible care the emotional elements which, in any particular case, its use involves.

The other tool that the clergyman uses in common with the social worker is the interview. The therapeutic use of the interview is of such importance and of such difficulty, and yet is so essential a tool for the clergyman, that to make any brief remarks on it may be merely misleading. No one can master the art. But it must be studied humbly and thoroughly; and some degree of proficiency in its use must be acquired by the clergyman if he is to function successfully as a pastor. One might as well attempt to be a physician without knowing the properties of drugs, or a surgeon without knowing how to use the knife, as attempt to help a parishioner recover his spiritual health without realizing that, from the very beginning—even while one is trying to understand and diagnose—a treatment process is under way; without knowing what to say, and, even more important, what not to say; without trying to look back of what the parishioner says and to understand its significance emotionally; without insight into one's own attitudes; without being able to evaluate con-

stantly the subtly changing relationship between himself and the parishioner; without being able to sense when the parishioner has acquired strength to go on on his own and no longer needs assistance.

One is tempted to give such counsel as that one should always be more ready to listen than to talk; that one should seek to understand and to evaluate; that never, under any except the most unusual circumstances, should one blame or censure; that one should realize that a most emphatic refusal is often a last desperate stand before acquiescence, and that apparent callousness, indifference, and hard-boiledness are often mere defensiveness; that one should be willing to understand and to accept rejection of one's self. But one hesitates to make these suggestions and others like them lest the impression be given that the art of interviewing can be acquired in any way except by arduous study and long practice. And even here we must be on our guard, because so much that has been written on interviewing—especially the attempts to reduce it to rules and to schematize it into "techniques"—is unhelpful and misleading. To use the interview as a tool successfully, the clergyman must not only study the right material, but he must also practice under guidance which is wise and competent.

In the use of the interview, the clergyman has one asset which the case-worker and the analyst ordinarily does not, and perhaps cannot, utilize. This asset is the positive ideal of the good life, as symbolized, for example, by Christ and the Cross; and the means, such as prayer and the Communion, by which these ideals are integrated in terms of feeling with the parishioner's life.

An illustration may help us to understand both the constructive use and the destructive misuse of this asset. Suppose a woman cannot love her husband because deep down in her unconscious self, as a result of early childhood experiences, she is blocked in the expression, not only of affection for her husband, but of all feeling. As a young child she was disciplined for expressing anger, hatred, and so forth, and a pattern was laid down by which she cannot now express love. Assume that her husband is good, faithful, and devoted. Merely to urge this on the woman—merely to say that the

husband is worthy of love and that therefore she ought to love him—increases her difficulty. This is to insist that she ought to do what she cannot. So also to urge the Christian ideal, or some phase of it, on a parishioner who is blocked from achieving it only increases the parishioner's difficulty. The sense of "oughtness" is heightened, but the inability remains.

But now suppose an analyst enables the woman to become conscious of her blocking. As I understand it, he depends upon her understanding and accepting emotionally what is blocking her to enable her to rise above it. But if her husband is a fine and lovable person, it will be much easier for her, on the positive side, to feel and express her love than if he were unattractive, mean, and self-centered. Even when a parishioner has been helped, not by the clergyman, but by a social worker or analyst, a wise presentation of the positive Christian ideal, and its feeling-integration through church worship and fellowship, should be most helpful. And, by analogy, although the parishioner whom the clergyman is trying to help cannot make any steps toward achieving the Christian ideal while he is blocked, once the blocking is removed, the presentation of the ideal intellectually and emotionally may make it easier for him to use constructively his new freedom.

Another important tool which the clergyman has ready at hand is the group.[1] Recently I read a case record, made by a social agency, which told how a woman who had not been helped by interviews with the worker was able, in a group, to express certain minor crimes of which she had been guilty, and to come to realize how they were blocking many aspects of her life. Our Cincinnati Church Mission of Help has a group of married mothers who, among themselves, are able to work out certain adjustments for lack of which they might well be blocked later in constructive aspects of their lives. I call your attention to these two examples to illustrate the use of the group in treatment. This use is becoming more and more widely recognized. In the magazine, *Parent Education,* you will find many articles illustrating how progressive educators are coming to value the group as a means of enhancing

[1] This has no reference to the groups of the New Oxford or Buchmanite movement.

the Good Life, and social workers also are beginning to utilize the group for this purpose.

The clergyman has the distinct advantage that he does not have to form groups. They already exist, or there are well-recognized purposes for calling them into existence. The parish, if it is small, is itself a group. Or a larger parish may be organized into neighborhood groups. The vestry is a group; the Woman's Auxiliary is a group; each church school class or department is a group. There may be many parochial groups for men and boys, for women and girls, and for young people, all of which have a "natural" reason for being, none of which has to be organized more or less artificially.

Without interfering with the objectives for which such groups exist, they may be used in treatment. They serve as a sphere in which the clergyman may give opportunities for constructive and satisfying experiences. So-and-so will be made president of a group, not "to hold his interest," but in order that he may gain or regain the self-confidence or sense of status which he needs in order to meet the experiences of life. The clergyman may use a group to create friendships between two people, each of whom may have some need of his own and yet be able to supplement the other constructively. Recently I was present at a church group in which, through a somewhat informal conversation, a father arrived at quite a clear understanding of the emotional needs of one of his children and what he could do to meet the situation, which I question whether he could have gained from an interview, however skillfully conducted.

An extremely important tool, which the clergyman alone has at his disposal, is the sermon. Sometimes the clergy undervalue the sermon and refer to it disparagingly as "mere preaching," but actually it is a great privilege and a weighty responsibility to talk to a group, no matter how small, for thirty minutes each week about leading the Good Life. Many sermons will be related only indirectly to the pastoral activity of the clergyman, but a considerable number may and should be used directly as a tool for pastoral work.

One of the problems of the clergyman, when he is trying to help men overcome what is blocking the development of

their spiritual selves, is when and how to use interpretation effectively—that is, when and how to discuss with the parishioner what is the matter with him. The clergyman will be tempted to give this information as soon as he knows it himself, or even before he knows it certainly, when he merely suspects that he knows what is the matter. It is not only that he does much damage when his diagnosis is erroneous, but also, even when it is entirely correct, the parishioner may not be able to receive it. He may reject the clergyman because he tries to give it, and even turn away from the problem of how to work out his difficulties rather than face a truth which is, at least at the moment, so unbearable. The clergyman may, for example, be pretty sure that what lies back of a child's behavior problem is that the mother identifies him with an unloved father whom she married merely for money. She does not love the father and she cannot love the son, and the behavior of the son is an attempt to punish the mother for not loving him. But if the clergyman tells the mother this prematurely, or perhaps at all, she may well be insulted, refuse to see him, and even reject religion in that it tends to make her face her guilt. But the sermon offers a means by which an interpretation may be offered in general terms. If some particular person is not ready to receive it, he may ignore it. But he may give it more thoughtful consideration in that there is no necessity for immediately accepting or rejecting it, as would often be the case in an interview; or he may accept it the more readily because it is presented as a general truth which he applies to himself, rather than as a specific diagnosis offered him individually.

We may think of the sermon as the art of using a conventional form and Bible material to express religion, partly as mediated through the personality of the preacher, but chiefly as applied by him to the spiritual needs of his particular congregation. It is an extremely difficult art, and one that tends to fall into disrepute because the clergy so often give it insufficient attention. But when it is well done, the preacher may speak for his entire half hour on, say, the impotent man waiting for the troubling of the waters of the pool, making perhaps no slightest reference to anything more recent in date than nineteen centuries ago—although to this, of course,

there may be many exceptions; but after the sermon is over, the member of the congregation sees it as his own particular trouble that he is always depending upon others instead of relying upon himself.

This does not mean that the clergyman will preach *at* some individual; it does mean he will think carefully of the needs of the individuals in his congregation—will plan and write his sermon so that this or that person will never suspect it is for his benefit, but through the medium of conventional forms and materials, will be given the truth he needs. If this is done in such a way that within two weeks this person comes to the clergyman and wishes to talk with him about the sermon in relation to his personal life, it has been an excellent piece of work. And this can be done—not every time—but frequently. And, curiously enough, the rest of the congregation is always interested, and sometimes thrilled, by such preaching.

It may be asked whether the confessional is not a tool which the clergyman should use in treatment. There is an ambiguity in the use of the term. When Dr. Fosdick, for example, speaks of the value of a Protestant confessional, he appears to be thinking of the availability of the minister for interviews when, but only when, people have need of help. Such a confessional is obviously an interview and nothing else—extremely valuable, but neither more nor less valuable because it is described as a confessional. But the confessional is a very different thing when it is a *regular* part of the religious life of the parishioner, continued regularly through his lifetime, and involving priestly absolution.

Here we run into a value and also into two great dangers.

If the parishioner is blocked by guilt, and if this guilt has been released adequately by other techniques, then it may be a great help, provided both the parishioner and the clergyman believe sincerely the latter has power to "remit sin," for the latter to do so. But note the qualification, "if the guilt has been released adequately by other techniques," for if the guilt is deep-rooted in the unconscious, and remains there as a destructive factor, the premature granting of absolution may well weaken the spiritual life of the parishioner and perhaps even set up new conflicts.

In addition to this, there is an especial danger to the clergyman himself. I write from the point of view of one who cannot find any adequate reason for believing that a clergyman has any power or authority in the forgiveness of sins other than declaring officially that God is by His very nature Love and Forgiveness. Others believe that they have such power and authority. Do they find evidence that I cannot? Or do they *want* to believe that they have this power and authority? There can be no question that many men enter the ministry motivated by a desire for power. Many a social case record shows how often the least effective boy in a family "thinks of going into the ministry," and many actually do so. Nowhere is there a power more like that of God Himself than in the forgiving of sins. It may amount to attempting to be God. Now it may be that God has given this awful power to the clergyman, or to the clergyman with some particular kind of ordination; it may be that there is evidence which I cannot find, or that my prejudice has blinded me to the evidence, but, on the other hand, how can one be sure that one is not seizing this awful authority because of one's desire for power? Can any man be even partially sure of this unless he has had a thorough analysis? And even if he is sure, must it not always be a tremendous danger that he may come to exercise the authority from desire for power rather than from purely religious motives?

For the parishioner also, the confessional which is a normal and continuing part of the religious life has a danger. In his use of the interview, the clergyman, like the social worker, strives to remove a blocking and to make the parishioner free to lead the Good Life on his own. He succeeds just in proportion as he eventually makes himself unnecessary. If he fails to make himself unnecessary, he weakens the parishioner by making him dependent. We recognize such dependency easily on the economic side: if, in the administration of relief, we weaken the will and the ability to earn a living independently, and the parishioner comes to depend upon us habitually for assistance, we blame him—although more properly we should blame ourselves—for becoming a chronic beggar. This is also true on the spiritual side. Life is sick and weakly if it can be lived only in dependence upon another

for constant sympathy and guidance. The question is whether the continuing confessional experience, unlike the interview, does not make for such spiritual dependency.[1]

In order to do pastoral work effectively, the clergyman must have adequate instruction and training. Mere college courses in psychology and economics, although valuable as a foundation, are insufficient. There must be, at the very least, a thorough study of the normal development of man's emotional life—how this is related to the physical and the mental, how it may be blocked by many obscure and subtle factors, and how these blockings find expression in symptoms. This will include some study of abnormal psychology, not because the clergyman is to be an amateur psychiatrist, but because a study of the abnormal increases our understanding of the normal. It should include some knowledge of how the analysts have interpreted human nature, and of the differing views of Freud, Adler, Jung, and Rank. The important thinking of these men about human nature, quite apart from the techniques which they use, is of very great value to the clergyman. It is important that he study either what these men themselves have written or what competent students, such as Flügel and Alexander, in the case of Freud, have written about them, rather than criticisms which are often superficial and sometimes downright stupid. Especially important for the clergyman are some of the later ideas of Freud. For example, his thinking on the ego, the super-ego, and the ego ideal, which is accessible conveniently in one of Dr. Alexander's books, is a discussion of conscience from the scientific point of view which is of the very highest value. Men whose consciences are forever preventing their being generous and kindly might find such a discussion infinitely more valuable than any amount of prayer and Biblical meditation.

The clergyman must also avail himself of those social-work techniques, especially the use of the interview, which social workers have gradually discovered. He is not going to become an amateur social worker, but he must utilize, as all other professional persons do, discoveries made in other fields

[1] There is a discussion of this in the preface of Kenneth Kirk's *Some Principles of Moral Theology* which is well worth reading, although the important note by Dr. J. A. Hadfield does not seem to give sufficient weight to the damage that may be done by dependency even on the conscious level.

which can be applied to his own. Often the clergyman shows great resistance to these social-work techniques. He feels that he can be more dogmatic and more moralistic than the social worker. But these resistances are merely symptomatic of his crying need of what social work has to teach.

How to become acquainted with these social-work techniques is, however, a difficult problem for the clergyman. Ideally they should be studied in relation to the use he will make of them, in the course of his own professional training at a theological seminary. The General Seminary of the Episcopal Church (New York) is said to be making an important experiment in this direction, but usually the clergyman's only opportunity of studying these techniques is to go over into the social-work field and then himself attempt to integrate what he has learned with the specific use he will make of it. The opportunity given by a few theological seminaries to count work at social-work schools toward graduation is an opportunity a ministerial student should welcome. Or he will do well to supplement his theological training with a year at a good school of social work, or, failing this, to learn what he can by taking occasional social-work courses and by cultivating the acquaintance of competent social-case-workers and agency executives and learning as much as possible through them, and through the reading they suggest.

Like other professional persons, the clergyman needs to serve an apprenticeship under competent supervision. Such an apprenticeship is a privilege, however, which it is difficult for him to secure. Theoretically, in the Episcopal Church, the diaconate is such an apprenticeship, but actually it usually has not been. It is encouraging to observe the attempts that are being made to make it what theoretically it is supposed to be. The difficulty with many of these attempts has been that they train men for some specialized service, rather than for a normal parochial ministry. After all, the great bulk of the clergy need training not so much in how to minister to the mentally ill, or to serve as hospital chaplains or as reformers of the social order, as in how to render service in the whole field of pastoral relationships, including, of course, a ministry to the ill and wise community leadership. We are hoping the Graduate School of Applied Religion, which began

its work in Cincinnati in September 1936, will pioneer successfully in giving the deacon this all-around apprenticeship experience. But even if it meets the success we hope for, there will still be the problem of making this apprenticeship a normal part of *all* ministerial training. The great difficulty will be in securing competent supervisors. In the beginning, reliance will have to be placed on clergymen who have trained themselves. Gradually, it may be hoped, men who have received this training, imperfect as it may be, will in increasing numbers acquire competence as supervisors. It will be a great day for the Christian religion; it will save untold numbers of the clergy from ultimate failure, despair, and comparative uselessness, when every man has a diaconate in the normal parochial field which is as effective as the training the externe receives in a social agency or the interne in a hospital of the first rank.

An Episcopal bishop once said that when, as a deacon, he was sent to his first mission, he visited his few parishioners once, then twice, and then a third time. By then his common sense told him the people would be bored if he made a fourth round of visits, but he did not know what else to do. This is the situation in which the clergyman tends to find himself. He is bored, and his people are bored, by a pastoral activity which consists of nothing except repeated social visits. In consequence, he diverts his energies into being an amateur psychiatrist, or a Rotary Club orator, or a bee-breeder. Or, failing such outlets for his activity, he settles down to a dull routine of services and to the preparation of even duller sermons for the complacent parishioners who attend services from a stern sense of duty.

This paper has attempted to show that there is another alternative—that there is a pastoral field which is the clergyman's own, in which he can render services of inestimable value and be thrilled constantly by the consciousness of real usefulness, provided he will read widely enough, study hard enough, work intelligently enough, and be sufficiently receptive of what he may learn from other professions.

CULTURE CONFLICT AND DELINQUENCY *

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MUCH has been said about criminality among the foreign born, and opinion evidence has it that the foreign born are largely responsible for our high crime rate and frequent "crime waves." Discriminating analysis of the available data, however, incomplete as they still are, lead to the conclusion that "in proportion to their respective numbers, the foreign born commit considerably fewer crimes than the native born."[1] Recent evidence from studies of juvenile-court cases and peno-correctional populations would seem to indicate that in proportion to their numbers in the general population the native born of foreign parentage contribute more to the criminal ranks than do the native born of native parents.[2] But it must be stated that absolutely conclusive proof of this fact does not yet exist.

In the *Report on Crime and the Foreign Born* made by the National Commission on Law Observance and Enforcement,[3] the conclusion was reached, after a sifting of the research data existing at that time, "that there is insufficient information available to warrant any deductions as to criminal activity among the native born of foreign parentage as compared with those of native parentage." Further casting doubt on

* Read at the Conference on Immigration Policy of the National Conference of Social Work, Atlantic City, New Jersey, May 27, 1936.

[1] See *Report on Crime and the Foreign Born* by the National Commission on Law Observance and Enforcement (Washington: Government Printing Office, 1931), Vol. 3, Part II, Section 14, p. 195.

[2] See *Five Hundred Criminal Careers*, by Sheldon and Eleanor Glueck (New York: A. Knopf, 1930. p. 119), and *One Thousand Juvenile Delinquents*, by the same authors (Cambridge: Harvard University Press, 1934. p. 85). See also *Juvenile Court Statistics* (Children's Bureau Publication No. 212. Washington: Government Printing Office, 1932), and *Crime and the Community, A Study of Trends in Crime Prevention*, by the Crime Commission of New York State, Subcommittee on Causes and Effects of Crime (Albany: J. B. Lyon Company, 1930).

[3] Loc. cit., p. 196.

the absolute conclusion that a higher proportion in relation to the general population of native-born delinquents spring from foreign than from native parentage is the statement made by the United States Bureau of Education[1] in 1928 as to the nativity of the inmates of 105 industrial schools in the United States during 1926-1927: "The percentages of those inmates which are native born of native parents, and of those which are native born of foreign or mixed parents, are about the same as the percentages for corresponding groups in the five-to-twenty-year class of the general population."

But whether or not the criminality of the native born of foreign parentage is excessive, there is a conviction among social workers, criminologists, educators, and others that the conflicts engendered by the differing cultures of native-born children and their foreign-born parents, and between them and the American environment, has something to do with explaining the delinquency in this group. So far, this is little more than speculation. There is some feeling, however, that these cultural conflicts are greater or more hazardous in certain nationality groups than in others. No researches are recorded (at least in American literature) in which a factor-by-factor analysis has been made of native-born offenders of native parentage and native-born offenders of foreign parentage and of different nationality groups. Such a comparison, by uncovering the influence of the factor of nativity in the criminogenic complex, should throw some light on the part played by clash of cultures in the etiology of delinquency, and should indicate whether culture conflict is related to delinquency regardless of racial differences.

The chief purpose of this paper is to place before you the results of a factor-by-factor comparison of the two classes of offenders—the native born of American-born parents and the native born of foreign parentage. Such a comparison has been made possible by a special analysis of the materials gathered for the study, *One Thousand Juvenile Delinquents*—a study of the boys who appeared before the Boston Juvenile Court during the years 1917 and 1922 and who were referred by the court to a children's clinic (the Judge Baker

[1] Department of the Interior, Bulletin 1928, No. 10, p. 1.

Foundation[1]) for diagnosis and treatment recommendations. These boys averaged thirteen years of age at the time of the arrest that brought them to the attention of the Boston Juvenile Court.

It should be clear at the outset that the group comprising foreign-born offenders were not utilized in the comparison because our present interest lies in the problem of delinquency among the *native born* of foreign parentage. Delinquency of foreign-born offenders has, as previously stated, already been explored by others. So also the group comprising the native-born delinquents only *one* of whose parents was of foreign birth. has been discarded for our present purpose in the interests of purity of comparison. Their elimination was decided upon only after an examination of the cases, factor by factor, showed them to resemble more nearly the native born of *native* parentage[1] than the native born of foreign parentage,[2] and to have few really distinguishing characteris-

[1] Now the Judge Baker Guidance Center.

[1] In 15 of 49 factors the native born of mixed parentage were found to resemble the native born of native parentage more closely than they did the native born of foreign parentage:

Factor	*Of mixed parentage*	*Of native parentage*	*Of foreign parentage*
One or both parents attended grade school	71.9%	72.2%	33.9%
Inadequate homes (broken or poorly supervised)	94.9%	95.0%	90.7%
Broken homes	53.9%	60.8%	35.3%
Conjugal relations of parents fair or poor	46.5%	52.5%	32.1%
Mother poor disciplinarian	76.0%	72.8%	69.2%
Poor physical home	45.1%	45.6%	68.4%
Average number of children in family	4.9	4.1	5.5
Illegitimate birth	6.3%	7.6%	1.5%
Early abnormal environmental experiences	50.3%	52.9%	28.9%
Mental disease or distortion or personality difficulty	64.8%	66.9%	53.5%
Average age at first known misbehavior	9.4 yrs.	9.5 yrs.	8.0 yrs.
Average age at first arrest	12.2 yrs.	12.3 yrs.	11.4 yrs.
Offense committed with others	62.1%	64.4%	74.3%
School misconduct	88.4%	90.6%	82.7%
Father unskilled worker	34.9%	38.7%	46.8%

[2] In 5 of 49 factors the native born of mixed parentage more closely resembled the native born of foreign parentage than they did the native born of native parentage:

Factor	*Of mixed parentage*	*Of native parentage*	*Of foreign parentage*
Average disparity in ages of parents	6.5 yrs.	4.5 yrs.	6.6 yrs.
Father affectionate to boy	67.1%	57.3%	71.1%
Irregular worker	78.3%	86.7%	81.7%
In street trades	56.7%	64.8%	59.1%
Offender first-born child	19.8%	36.1%	20.1%

tics of their own,[1] and many resemblances to the other two groups.[2] This left for comparison, therefore, two clean-cut samples, of which the group of native born of native parentage comprised 121 cases, and the group of native born of foreign parentage comprised 461 cases. The difference in the size

[1] In 5 of 49 factors, the native born of mixed parentage differed from the two other groups:

Factor	*Of mixed parentage*	*Of native parentage*	*Of foreign parentage*
Age of youngest parent at marriage	22.7 yrs.	21.6 yrs.	21.6 yrs.
Father poor disciplinarian	75.5%	68.3%	67.1%
Mother works out	44.6%	56.6%	36.9%
Has belonged to club	33.5%	24.1%	22.1%
Delinquency in parents	84.2%	77.0%	67.0%

[2] In 24 of the 49 factors, the native born of mixed parentage resembled both other groups:

Factor	*Of mixed parentage*	*Of native parentage*	*Of foreign parentage*
Mother affectionate	81.5%	80.7%	83.1%
Economic condition marginal	71.2%	68.2%	67.7%
Poor neighborhood influences	82.8%	81.7%	86.2%
Social agencies interested in family	87.7%	91.4%	88.6%
Average number of agencies	4.0	3.6	3.8
Family history of mental disease or defect	89.1%	89.1%	87.2%
Delinquency in family	89.9%	87.3%	88.5%
Intelligence normal or superior	42.6%	41.7%	42.4%
No talents	95.6%	97.5%	98.7%
No prior mental examination	93.0%	90.8%	92.5%
Average age at which began work	12.8 yrs.	13.0 yrs.	12.5 yrs.
Average number of arrests	2.3	2.1	2.4
Referred to Judge Baker Foundation from Boston Juvenile Court for property crimes	71.1%	67.8%	74.0%
Average length of time between first misbehavior and first arrest	2.8 yrs.	2.5 yrs.	2.6 yrs.
Average length of time between first misbehavior and J. B. F. examination	3.4 yrs.	3.5 yrs.	3.1 yrs.
Good health at time of examination by Judge Baker Foundation	56.9%	53.0%	56.2%
Recidivism	89.0%	93.1%	87.8%
Bad habits	76.1%	76.0%	79.6%
Criminal ideations, conflicts, dissatisfactions	15.1%	13.3%	13.2%
Harmful use of leisure	89.9%	94.0%	95.1%
Bad companions	90.5%	93.2%	95.1%
Entered high school	20.8%	25.4%	16.6%
Retarded more than one year in school	60.1%	58.0%	57.1%
Left school for economic reasons	65.6%	60.7%	64.3%

of the two series must of course be taken into account in making any comparisons between them.[1]

We will now proceed to a description of the native-born juvenile delinquents of native and foreign parentage, later drawing together the strands of resemblance and difference to see whether it can reasonably be said that culture conflict (in the sense in which it is used in this paper) explains some of the delinquency among first-generation Americans.

It might be well to state at this point that of the foreign parents in the group 46.2 per cent were of Italian birth, 19.5 per cent Irish, 15.6 per cent Russian, 8.9 per cent Polish or Lithuanian, 4 per cent Canadian, and 5.8 per cent of other nationalities; and that at the time of examination of the boys at the clinic, 59.6 per cent of the foreign-born parents had been in the United States over twenty years, 39.1 per cent between eleven and twenty years, and 1.3 per cent from six to ten years. It must be kept in mind of course that as the boys studied averaged thirteen years of age at the time of their examination at the clinic, their parents had been in the United States from a few months to about seven years at the time of the birth of the boys. It should be noted also that up to the time of the arrest of the boys for the offenses which brought them to the attention of the Boston Juvenile Court and the Judge Baker Foundation, only half of the foreign-born fathers had become citizens of the United States, 13 per cent had their first papers, and 38 per cent were aliens.

After these necessary preliminaries, let us first compare the parental and family characteristics of the two groups of delinquents. How did the native-born and the foreign-born *parents* of these two groups resemble and differ from one another in education, economic condition, and social status? What kind of physical and moral environment had the two groups of parents provided for these boys, as reflected in the character of their homes, the neighborhoods in which they lived, their moral standards, their conjugal relations, their

[1] An experienced statistician in the criminologic and anthropologic field advised that a difference of at least 5 per cent in the incidence of the subcategories of a factor was the minimum considered as constituting a real difference. In doubtful cases he advised that the probable error be computed.

emotional attitudes toward the boys, and their disciplinary practices?

What of the education of the parents? As might well be expected, by reason of the limited opportunities for schooling in foreign countries, the foreign-born parents had considerably less schooling than the native-born parents: 63.7 per cent of the former had never attended school as compared with 8.2 per cent of the native-born parents, and only 2.4 per cent of the foreign-born parents had had any high-school or college training as compared with 19.6 per cent of the native-born parents. Obviously, therefore, the educational equipment of the foreign-born parents for coping with the responsibilities of family life under the handicap of a strange culture was insufficient. Despite the difference in schooling, however, the two groups of parents maintained a like economic level to judge by their status at the time that their sons appeared before the Boston Juvenile Court and the Judge Baker Foundation; for 22.7 per cent of the native parents were then in comfortable circumstances[1] as compared with 24 per cent of the foreign parents; 68.2 per cent were in marginal circumstances as compared with 67.7 per cent of the foreign parents; and 9.1 per cent were dependent on social agencies or relatives for support as compared with 8.3 per cent of the foreign parents. Considering the odds against the foreign-born parents in establishing themselves in a new land, this similarity is noteworthy—and the more so because there were on an average 5.5 children per family among them and 4 per family in the native group.[2] The similarity in the economic condition of the two groups becomes even more striking in the light of the fact that only 36.9 per cent of the foreign-born mothers were gainfully employed, while 56.6 per cent of the native-born mothers worked to supplement the family income. In view of the high proportion of cases in both groups in which the families were on the border line of dependency (*i.e.*, in marginal circumstances) if not actually

[1] For definition of all terms used herein see *One Thousand Juvenile Delinquents*, pp. 322–30.

[2] These were, of course, incompleted families. But the comparison is significant because the cross section of time from which it is taken—the time at which the boy appeared before the Judge Baker Foundation—is the same in both groups.

dependent on others for support, the finding that an equal number of social-service agencies had had some contact with the two groups of families was to be expected—the average was 3.6 agencies in the native-born group and 3.8 in the foreign-born group.

In view of the lower educational status of the foreign-born parents, the finding was to be anticipated that a greater proportion of the foreign-born fathers than of the native-born—46.8 per cent as compared with 38.7—were unskilled workers (peddlers, teamsters, day laborers, porters, janitors, factory hands). But further examination reveals that almost equal proportions in the two groups were skilled workmen—29.0 per cent of the native born and 33.8 per cent of the foreign born. No doubt the system of apprenticeship practiced in many European countries accounts for this, despite the more limited schooling of the foreign-born parents. However, more of the native-born fathers were engaged in clerical occupations—8.7 per cent as compared with 2.2 per cent—and more were in the public service (policemen, firemen, postmen, conductors)—12.3 per cent as compared with 2.2 per cent. On the other hand, more of the foreign-born fathers had their own businesses (mostly small shops or stores)—11.2 per cent as compared with 2.6 per cent of the native-born fathers.

Despite the essentially similar economic status of the two groups, the homes in which the sons of the foreign-born parents were reared showed more disadvantages than the homes of the native parents. For 68.4 per cent of the homes of the former may be described as "poor" (overcrowded, dirty, shabbily furnished) as compared with 45.6 per cent of the homes provided by the native-born parents.

It is worthy of note, however, that this difference was largely absorbed by one racial group (the Italians). A comparison of their homes with those of the remainder of the native born of foreign parentage shows that 84.8 per cent of those of Italian parentage had poor homes as compared with 52.5 per cent of those of the other foreign stocks.[1]

[1] It was suggested to the author that some of the differences found between the native born of native parents and the native born of foreign parents might be explained by the preponderance of Italians in the latter group. To test this hypothesis, tabulations were made separately for the Italian group and, with

The homes of both native- and foreign-born parents were in almost equal proportions in neighborhoods in which the influences were vicious. There were gangs idling about on the corners, there were cheap poolrooms, dance halls, houses of prostitution, and other centers of vice and crime within close proximity. This was true of 86.2 per cent of the homes of the young delinquents of foreign-born parents and of 81.7 per cent of those of native parents.

Now what of the more subtle aspects of the home life of our boys as reflected in the moral standards of the parents, in their conjugal relationships, and in their attitude toward their sons? The moral standards of the foreign-born parents, as gauged by their delinquencies (official and unofficial), appeared to be higher than those of the native-born parents, for there was a history of delinquency among 67 per cent of the foreign parents and among 77 per cent of the native parents. Further evidence of the somewhat better moral standards of the foreign-born parents was revealed in the fact that but 1.5 per cent of the boys of foreign parentage were conceived or born out of wedlock as compared with 7.6 per cent of the sons of the native parents.

What other strands were woven into the fabric of family life by the relationship of the parents to each other and to these boys? In the foreign-born group, 67.9 per cent of the parents were compatibly married as compared with 47.5 per cent in the native-born group; and in a far lower percentage of the former did the marriages end in separation, desertion, or divorce before the boy was sent to the juvenile court—14.7 per cent of the foreign-born group as compared with 38.6 per cent of the native born.

In this connection it must be noted that in both the foreign and the native group, the average age of the younger parents at marriage was 21.6 years, but the difference in the ages of the parents was greater among the foreign-born parents than among the native-born—six and a half years as compared with four and a half. This difference in favor of the somewhat greater maturity (in most cases) of the foreign-born fathers may in part at least explain the greater stability

the exception of the striking difference in the physical aspects of their homes, it is not possible to make any explanation of the differences between the two groups on the basis of Italian predominance.

in the marital relationships of the foreign-born parents, which in turn may have its roots in the Old-World custom of affiancing the daughter of the family to an older and more settled man.

Although the mothers of both groups were equally devoted, 83.1 per cent of the foreign-born mothers and 80.7 per cent of the native-born mothers showing natural maternal affection, a greater proportion of the foreign-born fathers bore an affectionate relationship toward their boys than of the native-born fathers—71.1 per cent as compared with 57.3 per cent. But in disciplinary practices both sets of parents were equally recalcitrant, 67.1 per cent of the foreign-born fathers and 68.3 per cent of the native-born fathers being poor disciplinarians—that is, either extremely lax or very rigid in their control of their boys. The mothers of the two groups were poor disciplinarians to a similar extent—69.2 per cent of the foreign mothers and 72.8 per cent of the native being so classed.

Not only were the emotional ties stronger between the foreign-born parents themselves and between them and their sons, but their homes also appeared to be more stable as reflected in the fact that 64.7 per cent of them had remained unbroken up to the time the boys appeared before the juvenile court as compared with but 39.2 per cent of the homes of the native-born children of native parentage.

The greater stability of the homes of the boys of foreign parentage is further evidenced in the fact that not nearly the proportion of these boys had been subjected to abnormal environmental experiences (periods of living with relatives, placement in foster homes or protectorates, commitment to correctional institutions, and so on) as of the sons of native parentage—28.9 per cent as compared with 52.9 per cent.

To turn now to the boys themselves, the only clue we have as to whether or not there was an essential difference in the stock from which the two groups sprang lies in the similarity of the proportion of families in each in which there was a history of mental disease, distortion, emotional instability, or mental defect. We find such a history in the families of 87.2 per cent of the offenders of foreign parentage and of 89.1 per cent of those of native parentage. This

likeness is further borne out in the intelligence distribution of the two groups of boys, there being 42.4 per cent of boys of normal or superior intelligence among the sons of the foreign born and 41.7 per cent among those of the native born; 25.2 per cent with dull mentality among the sons of the foreign born and 25.2 per cent among those of native parentage; and 32.1 per cent of border-line or defective intelligence in the former group as compared with 30 per cent in the latter. Likewise equally few had any marked special ability (musical, mechanical, drawing, painting), the percentage being 1.3 for the sons of the foreign parents and 2.5 for the sons of the native parents. Clinical examination of these boys revealed criminalistic or sex ideation, conflicts about parents, sex and other conflicts, school, vocational or other dissatisfactions in 13.2 per cent of the boys with foreign parents, and in 13.3 per cent of the boys of native parents. Despite all these similarities, there was actually less mental pathology present in the delinquent boys of foreign parents than in those of native parents, only 9.7 per cent being psychotics, psychopaths, or epileptics as contrasted with 15.7 per cent of the sons of native parentage. In addition to this a lower proportion of the sons of the foreign born had what might be called peculiar personalities or personality difficulties, or showed marked adolescent instability—43.8 per cent as compared with 52.8 per cent—making a total of 53.5 per cent of the sons of the foreign born with mental distortions (not counting mental defects) and 66.9 per cent of the sons of the native born. Perhaps this is partly due to the fact that a far lower proportion of them were first-born children—20.1 per cent as compared with 36.1 per cent of the sons of native parents.

In the state of their physical health as discovered at the time of the clinical examination, the two groups of boys again resembled each other, 56.2 per cent of the sons of the foreign born being in good health as compared with 53 per cent of the sons of the native born.

It is a striking fact that the sons of the foreign-born parents were on the average a year and a half younger than the sons of the native parents at the onset of their delinquent behavior, the average age of the former being eight years

and of the latter nine and a half years. Likewise they were a year younger on an average at the time of their first arrest—11.4 years as compared with 12.3 years. However the two groups of boys had been arrested about the same number of times prior to their examination at the clinic, the sons of the foreign born 2.4 times, the sons of the native born 2.1 times. And the average length of time that intervened between the onset of delinquent behavior and the first arrest was approximately the same for both groups—2.6 years as compared with 2.5 years. The same was true with regard to the length of time between the first known delinquency and the clinical examination, which was respectively 3.1 years and 3.5 years.

Can the difference in the ages of the two groups at the earliest onset of delinquency be attributed to a more excessive or more serious tendency to delinquency among the sons of foreign-born parents? Several indirect lines of evidence should help us to answer this question. First it should be noted that despite the difference in the ages of the two groups of young delinquents at the onset of their misbehavior and their first arrest, there is only a slight difference in the types of offense that they committed, as judged by the offense for which they appeared before the Boston Juvenile Court and the Judge Baker Foundation, 74 per cent of the sons of the foreign born having been arrested for property crimes (larceny or burglary) and 67.8 per cent of the sons of the native born.[1]

Further evidence of the fact that the two groups of boys were almost equally delinquent despite the earlier onset of misbehavior manifestations among the sons of the foreign parents lies in the proportion who had bad habits (drunkenness, gambling, bad sex habits, habitual lying, smoking before the age of thirteen)—79.6 per cent of the sons of foreign-born parents and 76 per cent of the sons of the native-born parents. In their harmful use of leisure the two groups also resembled each other, 95.1 per cent of the sons of the foreign-born parents using their spare time harmfully as compared with 94 per cent of the sons of the native-born parents. Their

[1] In addition to the slight preponderance of so-called serious offenders among the sons of the foreign born, a greater proportion of them committed these offenses in the company of other boys than did the sons of the native born—74.3 per cent as compared with 64.4 per cent.

companionships also were to a like extent bad, 95.1 per cent and 93.2 per cent respectively running about the streets and in the alley ways of overcrowded and vicious neighborhoods with other children of questionable reputation. And, further supporting the similarity in their history of misconduct, 77.9 per cent of the sons of the foreign born and 75.9 per cent of the sons of native parentage had never belonged to any clubs or organizations for the constructive use of leisure.

These similarities lead to the conclusion that the earlier onset of misbehavior in the two groups must be explained otherwise than on the basis of the greater or more serious delinquency of the sons of the foreign-born parents.

Now what of the schooling of the two groups of boys? In view of their like intelligence, we are not surprised at the finding that the percentage of those who were at least in the grade normal for their age, if not advanced for their age, was practically the same in the two groups—19.7 per cent for the sons of native parents and 18.0 per cent for those of foreign parentage. The remainder were from one to four years behind grade for their age.

Although it is somewhat difficult to arrive at any conclusion in regard to the extent of the schooling of the two groups, since at the time these boys were under study half of them were still attending school, it is evident that of those who had already completed their schooling almost the same proportion of the two groups left upon completion of the fifth grade (12 per cent as compared with 15.4 per cent), the sixth grade (13.6 per cent as compared with 13.0 per cent), the seventh grade (27.1 per cent as compared with 30.2 per cent), and the eighth grade (22 per cent as compared with 24.8 per cent). However, a higher proportion of the sons of native parents than of the sons of foreign parents entered high school (25.4 per cent as compared with 16.6 per cent). Of those who had already left school a like proportion in the two groups had done so for economic reasons (60.7 per cent as compared with 64.3 per cent).

Despite the marked resemblance in the school history of the two groups, there is a difference evident in their behavior in school. The sons of the foreign parents showed a somewhat lower tendency to misbehavior in school than the sons

of the native parents—82.7 per cent of the former having played truant from school at one time or another, or stolen, or otherwise seriously misbehaved, as compared with 90.6 per cent of the latter.

As the two groups of boys came from homes of low economic status, it is natural to find that they entered gainful employment at an early age and on part time after the school day. The average age at which the sons of the foreign parents began to work was twelve and a half years, while the sons of the native parents first entered gainful employment at the average age of thirteen years. Three-fifths of both groups were early absorbed into the street trades or in night work—59.1 per cent of the sons of the foreign born and 64.8 per cent of the sons of the native born. Hence the environmental hazards were in this respect alike in both groups of cases. At least up to the time of examination by the Judge Baker Foundation clinic, like proportions of both groups of boys were for the most part irregularly employed—81.7 per cent and 86.7 per cent.

We now have the available facts before us. Let us briefly draw together the several strands of similarity and difference between the native-born delinquents of native parents and those of foreign parentage, keeping in mind our objective of determining whether or not culture conflict (as revealed through the differing nativity of parents and children) may be regarded as a factor contributory to juvenile delinquency among the children of the foreign born.

First of all, let us summarize the factors of resemblance in the two groups. We have found that both were at an equal disadvantage in the youth of their parents at marriage, in the low economic status of their parents, in the poor neighborhoods in which they were reared, in the extent of mental disease or defect among their parents and siblings, in the poor disciplinary practices of their parents. The sons of native parentage also resembled those of foreign parentage in the extent of their poor health, their low intelligence, their few special abilities, their many bad habits, their harmful use of leisure, their bad companions, their lack of constructive recreational supervision, their school retardation, their early leaving of school largely for economic

reasons, and their early employment in street trades. Further, the two groups had been arrested an equal number of times on the average; the lapse of time from the onset of their first misbehavior to their first arrest was the same; and the time between their first misbehavior and their examination by the clinic was the same.

So much for the likenesses. What are the essential differences between the two groups? First, we have a few differences that are readily accounted for on the basis of racial custom. For example, we have seen that there is a greater difference between the ages of the foreign-born parents than between those of the native-born parents. This is probably explainable on the ground that it is customary in European countries to affiance a girl to a man considerably older than herself. Likewise we can account for the more meager education of the foreign-born parents by the fact that compulsory education does not exist in most European countries even to-day. This in turn explains why a slightly lower proportion of the children of the foreign-born parents entered high school than did the sons of the native born, and also why they were on the average six months younger when they began to work than the sons of the native born. Such are Old-World customs. The lesser amount of schooling of the parents also accounts for the somewhat greater proportion of unskilled workers among the fathers, but the European practice of vocational apprenticeship explains the slightly greater proportion in the latter group of men in the various trades. The somewhat larger families of the foreign born, accounted for probably by the lesser use of birth-control methods because of religious scruples (81 per cent of the foreign-born parents were Catholics as compared with 56 per cent of the native-born parents) in turn probably account for the greater crowding of their homes.

So far these differences spring from the foreign birth of the parents and though not necessarily disadvantageous to the sons of the foreign born, are nevertheless not positive assets. But the following circumstances are decidedly advantageous to them: The conjugal relations of the foreign-born parents were far better; far fewer of their homes were broken by the death, desertion, separation, or divorce of their par-

ents; a far greater proportion of the foreign-born fathers were fond of their boys than of the native-born fathers; far fewer of their mothers worked out of the home.

Turning now to the boys themselves, we have seen that fewer of those of foreign parentage were illegitimate children than of the sons of native parentage; far fewer had been subjected to emotionally upsetting environmental experiences such as placement in foster homes or institutions or other separations from the parental roof. Far fewer were first-born sons, who are traditionally the "spoiled children" of large families, and fewer had mental aberrations or emotional peculiarities. Fewer, also, manifested behavior difficulties in school; fewer committed their depredations alone. They tended more than did the children of native-born parentage toward so-called "companionship affairs," which would indicate that to some extent at least they were led into the commission of crime by others. This may explain the fact that a slightly higher proportion of the sons of the foreign parents committed property crimes than of the sons of the native born.

Finally, we may review the small group of factors that, in the light of the more favorable environmental circumstances and the lesser degree of mental pathology among the sons of the foreign-born parents, are of the utmost significance. The sons of the foreign born were a year and a half younger than the sons of the native born at the time of the onset of their early misbehavior manifestations; they were a year younger than the others at the time of their first arrest, and a year younger at the time of the particular arrest that brought them to the attention of court and clinic. It is to be remembered in this connection that the two groups of boys had had a like number of previous arrests, and that a like amount of time had elapsed between the first manifestations of serious misbehavior and the first arrest, and between the first misbehavior and examination by the Judge Baker Foundation. Therefore the earlier onset of delinquency in the sons of the foreign born was clearly not contingent upon their greater delinquency or greater predisposition to delinquency, because, as has been noted, they showed less mental pathology and had a more favorable surrounding atmosphere than the sons of the native born.

Before, however, permitting ourselves to draw any conclusions from the facts here presented, it would be well to see whether the pattern of likeness and difference revealed by the delinquent boys of native and foreign parentage is substantiated in another group of offenders—of the opposite sex, of different racial composition,[1] and coming from all over the state rather than from one city.

Let us therefore turn our attention very briefly to a group of delinquent girls.[2] These girls came from all over the state of Massachusetts into the Massachusetts Reformatory for Women. A brief résumé of those facts of their childhood history that are entirely comparable with the facts presented for the boy delinquents is here given so that we may see whether or not the group already described is fairly typical of delinquents or whether it represents for one reason or another an atypical group.

A comparison of the native-born girl offenders of native parentage (152 girls) and the native-born of foreign parentage (121 girls) reveals, as it did in the group of boys, that their parents had less education than did the native born; 30.1 per cent of the former were illiterate as compared with 10.7 per cent of the native-born parents, while only 1.8 per cent among the foreign parents entered high school as compared with 5.7 per cent of the native born. Likewise a lower proportion of the daughters of foreign parents entered high school—4.4 per cent as compared with 10.2 per cent of the daughters of native parents. And as in the case of the sons of the foreign-born parents, the daughters of the foreign born were somewhat younger than those of native-born parents when they began to work, their average age being 14.1 years as compared with 15.2 years. Like the delinquent sons of foreign-born parents, the delinquent girls of foreign parents were children of larger families, the average size of the family being 7.2 as compared with 5.7. And also like the delinquent boys of foreign parents fewer of the delinquent girls came from broken homes—52.5 per cent as compared with 64.9

[1] See footnote p. 64.

[2] Originally reported in *Five Hundred Delinquent Women*. The tabulation required for the present purpose of comparing the native-born girl offenders of native parentage with those of foreign parentage has been especially prepared for use in this paper. The detailed findings have not been published.

per cent. Like the boys, also, fewer of the girls of foreign parentage were illegitimate children—4.3 per cent as compared with 11.6 per cent among those of native parentage. Similarly the conjugal relationships of the foreign-born parents were better than those of the native-born parents, the relationship between parents in the former group being good in 53.4 per cent of the cases as compared with 39.6 per cent of native-born parents. The differences between delinquents of native and foreign parentage are further borne out by the fact that the girls of foreign parents, like the boys, were a year and a half younger at the time of their first misbehavior, the average being 13.5 as compared with 14.9 years. And similarly they were on the average a year younger at the time of first arrest, the mean being 19.3 years for the daughters of foreign parents as compared with 20.7 for the daughters of native parents. And as in the case of the boy delinquents, fewer of the families of the girls of foreign parentage had among them delinquent members—75.6 per cent as compared with 89.1 per cent.

Although in certain other respects the girl delinquents of native and of foreign parentage differ from each other in ways in which the boys did not show differences, these only further accentuate the fact that the children of foreign-born parents had more advantages in certain respects than the native-born delinquents of native parents. For example, more of these girls attended church regularly during their childhood—67 per cent as compared with 41.4 per cent of the daughters of native parents. Further, a lower proportion of them moved about a great deal during their childhood—51.2 per cent of the daughters of foreign-born parents as compared with 62.9 per cent of the delinquent daughters of native-born parents. The moral standards of the homes of the native-born delinquent girls of foreign parents were higher than those of the native-born delinquents of native parents, being good or fair in 58.8 per cent of the cases as compared with 38.7 per cent of the cases of daughters of native parents. We find also that the economic condition of the foreign-born parents of delinquent girls was better on the whole than that of native-born parents, only 10.9 per cent of the former group being in dependent circumstances as com-

pared with 19.9 per cent of the latter group. The girl delinquents of foreign-born parents had the further advantage that during their childhood 78.2 per cent of them made their homes with both their parents as compared with 61.5 per cent of the daughters of native parents. And unlike the boy delinquents, the two groups of whom apparently had a like heredity in respect to mental disease and defect, 51.7 per cent of the daughters of foreign parents had no such history in their families as compared with 33.9 per cent of the daughters of the native parents.

It will be recalled that the physical condition of the homes of the boy delinquents of foreign parents was considerably worse than that of the delinquents of native parents. This was largely accounted for, however, by the preponderance of a particular racial group. Among the girl delinquents the physical homes were no worse in the group of foreign parentage than in that of native parentage.

Now we come to a group of factors in which the boy delinquents of native and of foreign parentage resembled each other, but in which the girl delinquents of foreign parentage were at a disadvantage as compared with those of native parentage. The character of these factors suggests that young delinquents of foreign parentage are perhaps subjected to even worse environmental influences than those of native parentage, even though they have advantages over the others in so many ways.

It will be recalled that the neighborhood influences were equally bad among both groups of delinquent boys during their childhood. In the group of girl offenders the neighborhood influences were somewhat worse in childhood among those of foreign parentage than among those of native, 36.9 per cent living in poor neighborhoods as compared with 26.8 per cent of those whose parents were born in the United States, and this despite the fact that the economic condition of the foreign-born parents was better than that of the native-born parents. It will also be recalled that among the boy delinquents there was an equal proportion in the two groups who utilized their leisure time harmfully. Although we do not have this datum strictly comparable in the case of the childhood of the girl delinquents, it would appear that those

of foreign parentage used their leisure less effectively than those of native parentage, as evidenced in the fact that only 13 per cent had constructive recreations and interests as compared with 22.7 per cent of those of native parents; 26.3 per cent of those with foreign-born parents had very questionable haunts as compared with 19.3 per cent of those of native parentage; and 36.6 per cent of the former had harmful companions during their childhood as compared with 21.5 per cent of the latter. So it looks very much as if, despite their better home situations, the girls whose parents were born abroad ran about the streets with even less supervision than did the girls with native-born parents.

Many other similarities and contrasts are evident from the materials available regarding delinquent girls. These may be more fully reported at another time and need not for present purposes be amplified here.

Certainly the evidence gained from the check group of delinquent girls, coming as they do from all parts of a state and not from one city in that state, and showing a very different ethnic composition from the groups of boys,[1] is essentially corroborative of the original findings. If anything, it further accentuates the differences between native-born offenders of native parentage and native-born offenders of foreign parentage in the direction of a weighting of the scales in favor of the delinquents of foreign parentage. It certainly seems clear that there is less apparent reason for the delinquency of the offenders of foreign parentage than for that of the offenders of native parentage. They seem to have an advantage in several ways, so that even if it were true that the native born of foreign parentage do not furnish a higher incidence of delinquents in proportion to their numbers in the population than the native born of native parents, it would still follow that *there is less reason why native-born offenders of foreign parentage should become delinquent. A reasonable hypothesis, therefore, is that in the conflicts and*

[1] Thirty and six-tenths per cent of the foreign-born fathers were French-Canadians, 27.3 per cent were Irish, 8.3 per cent were English-Canadians, 6.6 per cent were English, 6.6 per cent were Italians, 9 per cent Poles or Lithuanians, 4 per cent were Portuguese, .8 per cent Russian, and 6.6 per cent were distributed among other nationalities. A comparison with the country of birth of the foreign-born fathers of our delinquent boys shows how very different the distribution is. See p. 50.

problems resulting from the differing nativity of parents and children (regardless of racial composition) lies part of the reason at least for the delinquency of those of foreign parentage, since the only completely differentiating characteristic between the two groups is contained in this factor. Just what the components of this factor may be will have to be determined by those who work closely with first-generation Americans, and should be the subject of fruitful research.

So that, without question, this factor of culture conflict in its many ramifications plays a rôle in the etiology of delinquency among first-generation Americans. Its relative weight in the entire causal complex cannot, of course, be established without more accurate knowledge of the proportion of native-born offenders of native and foreign parentage in relation to the incidence of these nativity groups in the general population. But for the present this is beside the point. Even should the facts ultimately point to the conclusion that the native born of foreign parentage do not have an excessive incidence of delinquency, the fact that they are more favorably circumstanced in so many ways would still justify the hypothesis that the element of culture conflict in one way or another plays a considerable rôle in the delinquency of children of foreign parentage, and this regardless of racial composition, so clearly revealed by the study of the check group of delinquents. Logically these first-generation American children, with their special advantages over the native-born delinquents of native parentage, ought to contribute a lower proportion to the delinquent ranks than the others.

These findings should serve as a guide to social planners in making a concerted attack upon the problem of delinquency among first-generation Americans. It is to social workers, teachers, and others who are actively occupied with the welfare of children of the foreign born that the details of the plan of attack should be left. They must obviously first bend their efforts toward a clear statement of what are the components and the closely associated problems of the differing nativity of parents and children. They should then be ready to muster the social forces which have thus far been beating rather blindly upon children of the foreign born, early driving some of them into antisocial behavior as a protest against

the peculiar conditions which surround them at home, in school, in the neighborhood, directly as a result of the fact that they are native-born children of foreign parents (regardless of the nationality of their parents).

A mustering of social forces should, in the light of the facts here disclosed, result in a rich harvest to America by preserving to good citizenship a host of first-generation Americans of all nationalities. To this task we may optimistically bend our efforts.

A PSYCHOLOGICAL APPROACH IN CERTAIN CASES OF ALCOHOLISM *

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I REALIZE that it would be impossible in the short space available to describe the various subdivisions of the psychotherapeutic treatment advocated by the late Richard Peabody, which I use in treating abnormal drinkers; at best, I could leave only a vague impression of the treatment as a whole. Therefore, I will limit this paper to the approach that may lead up to a successful termination of a very common and destructive addiction.

My work with abnormal drinkers has been made possible by the generous help and coöperation of the psychiatric group and the general practitioners in Philadelphia and its vicinity, as my layman status makes it impossible for me to treat the condition in any but a non-medical field. This has a psychological advantage in that those who consult me, with the approval of a physician, come with a beginning already made.

First, they have admitted that they are abnormal drinkers, an essential admission before treatment can be given.

Second, the suggestion has been given by a physician whom they respect that there is a way to overcome alcoholism for a group of addicts who are not psychopathic, but who have sprung from a vast legion of psychoneurotics, those so-called nervous individuals who have found that a perverted indulgence of the intoxication impulse may serve as a temporary compensation for a maladjustment of personality. This type of neurotic alcoholic is unwilling to be considered either insane or stupid; for this reason the best approach to a specialized treatment can be made by the physician, who is usually present at the psychological moment when the patient cries for help.

* Read before the Chester County Medical Society, West Chester, Pennsylvania.

Once a patient has sought aid, the clinical picture of alcoholism permits little opportunity for a misdiagnosis. You distinguish the neurotic from the normal, though perhaps heavy, drinker by his inability to control his drinking and the stupidity of his sacrifice of the most valuable things in life for the state of mind produced by his alcoholic indulgence. Usually we find an uncontrolled drinker utilizing self-deception, one phase of which is his forever blaming his addiction on the conditions of his environment. In so doing he is only following in an exaggerated way the same procedure practiced by his controlled-drinking brothers, whose nervous systems *are* resistant to alcohol.

The controlled drinker usually wishes to have an excuse for indulging himself. He drinks because it is hot, or because it is cold; he drinks to prolong a pleasant occasion, and he cheers himself up with a drink when he is unhappy. In fact, to him alcohol is a sort of psychic Aladdin's lamp, which he uses to alter mentality. There is a vast difference between this type and the uncontrolled drinker. The line separating abnormal drinking from social drinking is a matter of the degree to which the drinker is psychologically dependent on the drink. This in itself is a fairly accurate indication whether the personality has or has not made a good adjustment to reality. We find well-adjusted people using alcohol in its accepted legitimate field, and though they may be far more addicted to it than they wish to admit, they are able to limit their indulgence in it to given occasions, because, having made good adjustments to reality, reality is acceptable to them. They may for a little while put on the mask and costume of a psychic harlequin, but after an hour or two they are quite ready to get back into their own more sober psychic garments, even though they know that this change may be accompanied by headache and frazzled nerves. On the other hand, the alcoholic, with his psychoneurotic maladjustment, is searching for the psycho-medicinal properties of alcohol rather than the pleasurable intoxicating effects.

Physicians who are familiar with the anæsthetics, ether and chloroform (the medicinally used narcotic intoxicants), have ample opportunity to observe, in the operating room, the

exciting phase followed by complete anæsthesia. At cocktail hour in any hotel or club bar, you will see the social use of narcotic intoxicants by an earnest group who are searching for and finding the exciting phase and the relaxing phase in a narcotic intoxicant disguised as a highball or a cocktail, and having found this pleasurable phase, they are satisfied. The abnormal drinker in the same situation is getting drunk quickly because he is searching for the anæsthetic properties or *deeper* narcotizing effects of alcohol. Hence we observe him hurrying through the exciting pleasurable and relaxing phase brought about by drinking in much the manner of one anæsthetizing himself. When you question the abnormal drinker about this peculiarity, he assures you that he did not mean to get drunk, nor did he want to get drunk; and I believe that consciously he means what he says, not recognizing the fact that unconsciously there is a demand for the oblivion of drunkenness, once the higher nerve centers have been affected by alcohol.

The other day one of my friends who was consulting me about his abnormal drinking said, "If you would only say that you could teach the abnormal drinker how to drink in moderation, you would have thousands flocking to your door." This is undoubtedly true, but if I made any such claim, I should be the most unmitigated liar, and those who consulted me would be doing so with no chance of success, for the simple reason that normal intoxication is not what the alcoholic is after, nor is he ever satisfied with it. The proof of this statement is obvious. No one makes these people seek drunkenness, and yet that is the state in which they inevitably arrive, if they use alcohol in any form whatsoever.

It is difficult to give a textbook definition of the underlying neurotic condition that makes alcoholism possible in certain individuals. It is perhaps most nearly covered by the definition of "compulsion neurosis" as given by Professor Horace B. English:

> **"Group of mental disorders characterized by an irresistible impulse to perform some apparently unreasonable act or to cherish an unreasonable idea or emotion. Generally the patient is not deluded and frankly admits the unreasonableness of his attitude."**

This definition would, of course, apply to the alcoholic only when he has been sobered up, as the effects of alcohol may create a delusional state.

The causes of an alcoholic compulsion neurosis are soon apparent in a coöperative patient anxious to aid therapy by unburdening himself of his innermost thoughts and reaction. Usually we find a marked lack of mental hygiene in the early parental environment. Often one or both parents have failed to make adequate adjustments to reality and they pass on to their offspring, by suggestion and tactless handling, a predisposition to maladjustment in maturity.

Citing from cases which I believe I have analyzed correctly, I find overprotection in childhood is often projected into adolescence and maturity as an abnormal dependence on the state of mind produced by alcohol. For instance, a mother consulted me about her grown son. She was active in the prohibition movement and a strict disciplinarian in the home, over which she domineered in a tyrannical manner, utilizing her fanatical interpretation of right and wrong to justify her every intolerant attitude. At thirty-one, her son was ruled by, and depended on, his forceful mother. He was still waiting for her to manipulate the puppet strings. At the same time he resented this forced dependence, and so he rebelled and hurt her in her tender spot—prohibition—by seeking escape in chronic alcoholism, ironically enough still depending on her in a way that she decidedly did not like.

Not infrequently the overprotection resulting from inherited wealth seems to turn out ill-equipped personalities that find an escape solution in alcohol. Many rich men, free from the necessity of earning their bread in a business or a profession, seek to suppress their creative urge by substituting alcoholic phantasies. Such men find in alcohol a synthetic existence which apes the give and take of normal life (emphasis always being on the take). This type might be described as perpetual euphoria seekers. They usually must endure a severe alcoholic breakdown before they learn the primary equation of life—that "you can't get something for nothing."

Among the neurotics who become alcoholic we occasionally find an initial adjustment to a smooth, uneventful environ-

ment, with no abnormal dependence on alcohol until an emotional shock is experienced. Then they start searching for a stabilizer and often find it and utilize it with little realization that they have developed a psychopathological addiction. War experiences and business failures have produced a group of these men who might under other circumstances have gone through life as normal drinkers. Occasionally a gonorrhœa infection and the mental reaction to it have seemed to herald an abnormal addiction to alcohol. One man traced his narcotic use of alcohol to the fact that, after a severe infection, the doctor who was treating him said that if he started to drink and there was no return of his symptoms, it would be a proof that the condition was cured. He went on a drinking spree and though he had been a controlled drinker up to the time of this incident, he found, after his humiliating experience, that alcohol offered him a solace for the shame and feelings of inferiority which the disease had caused. From this time on, he said, he used alcohol more and more as a psychic cure-all.

Marital discord is often used as a reason for drinking, but this is usually a cart-before-the-horse explanation whose falsity is evident as soon as the patient gains real insight into his personality maladjustment. The truth is that marriage enlarges the field of reality and increases responsibility, the very things the alcoholic was seeking to avoid by his narcotic use of alcohol. Hence the conspicuous failures of those women who marry in order to reform their inebriate lovers.

An arrested psychological sexual development is sometimes found at the bottom of discord between wife and alcoholic husband. The husband blames his drinking on the wife's lack of affection. The wife, on the other hand, is sexually dissatisfied and growing more so because of the impotency of her husband, which is exaggerated by alcohol. Such a circle becomes ever more vicious, the husband's sense of inferiority being increased by his wife's attitude, which further inhibits the possibility of a normal sexual adjustment. To add to the confusion, the husband considers alcohol as an aphrodisiac, not realizing that the drug that narcotizes his inhibitions is equally narcotizing his sexual power, so that

metaphorically he is using gasoline to put out the fire. I have recently had the pleasure of seeing a case of this sort gradually work out into a normal adjustment. The insight gained and the readjustment of the personality after reëducation, which was undertaken to overcome the alcoholism, automatically took care of the sexual immaturity. This adjustment could never have been made on any but a non-alcoholic basis.

The double standard of drinking which came about during prohibition has increased the number of feminine inebriates. I have found this condition harder to treat in the limited number of women who consult me. They seem to find it more difficult to be absolutely frank about themselves. However, where they can see the necessity of strict truthfulness and are sincere in their desire to overcome abnormal drinking, they respond to therapy in much the same manner as men. The underlying cause in women and in men is the same—*i.e.*, emotional immaturity, which renders their personalities unequal to the task of facing reality. In their narcotic use of alcohol they find the answer at least temporarily, and to the emotionally immature the temporary solution is sufficient. This temporary escape from reality is soon extended into days and weeks.

Most of those who wish to take formal steps to overcome their alcoholism are between the ages of thirty and fifty. This is perhaps a psychological time, because under thirty the driving force of youth and a nervous system that can withstand repeated alcohol shocks are reasons for not taking the alcohol problem seriously. After thirty the abnormal drinker gradually becomes aware that his drinking is forcing him to pay an exaggerated price mentally, morally, and physically, and his inability to limit his drinking to even the dissipated variety of indulgence is brought home to him by repeated unsuccessful attempts. By this time the penalty that one must pay for breaking any law of nature has become an obvious fact, no longer to be dismissed with a shrug and a smile as it was in young manhood. In the last analysis, I should say that the instinct of self-preservation is aroused only when the situation is so bad that it cannot fail to cause the gravest apprehension and alarm.

Having experienced fifteen years as a chronic alcoholic, I doubt whether any of us in the alcoholic brotherhood want to get well without reservations. Alcohol means too much to the man who is using it psycho-medicinally for him to want to give it up in its entirety. The best that can be hoped for is that he shall want to get well. Such a state of mind is sufficient at least to get him to consult some one who can show him how to help himself. Whether or not he will undergo treatment is another matter, but usually if he gets as far as this, he is on his way to a more mature handling of his problem. Bringing himself to this point amounts to a formal admission on his part that something definite must be done.

In the first interview with the patient I explain that I have been alcoholic and that I understand and sympathize with what he is going through; after which I ask him to describe his own case in his own way. I take down the history of his case as he gives it. I ask him to state when he first realized that his drinking was abnormal. I ask him his reasons for consulting me and get him to describe his early environment and his present environment. This may take several interviews during which I do not commit myself as to whether or not I think he is a fit subject for this type of work. I give him a copy of Richard Peabody's book, *The Common Sense of Drinking,* and ask him to mark any passages in it that he thinks are applicable to his case. Though I find that many of these men have read Peabody's book, they have little more than a superficial understanding of their own problems, probably because, at the time they read it, they were unwilling to project themselves into the position of one in need of treatment. This marking of the book and the subsequent discussion of it put psychotherapeutic treatment on a sound basis from the start. The patient has shouldered the full responsibility of the admission that he is one of those with a nervous system non-resistant to alcohol. It is a form of self-analysis, and the patient usually appreciates, and is impressed by, the fact that he is believed in and to a certain extent is allowed to act as his own analyst.

It has been my experience in this type of treatment that it is best never to attempt to convince a man that he is an abnormal drinker; rather I put it to him that he must convince me,

and incidentally himself, that he is in need of instruction in methods of helping himself. I take my cue from Peabody with this approach, and I remember my own shocked amazement in one of our early talks when he said somewhat as follows: "If you have any idea that you can still drink in moderation, there is absolutely no use in your consulting me. If you really believe that you can drink in a controlled manner despite what you have been through, the best thing for you to do is to go out and try. Then if you fail, come back to me and I will be glad to go into the matter further." This approach is a shock to most men who have spent many years as abnormal drinkers. Heretofore they have been surfeited with advice as to what they can and what they cannot do. They have been told that they must never have liquor in the house, they must avoid associating with their friends who drink, their wives must under no consideration take anything to drink. Very often they have been advised to leave their environment and attempt to make a new start in a community in which there is no drinking. In the first place, I don't know of any such community, and in the second place, such advice amounts to telling a man that he is a weakling and advising him to escape reality, which is the very thing he has been attempting to do by his abnormal use of alcohol. The psychological approach which I have found effective is that of accepting the prospective patient as an individual who is perfectly able to stand on his own two feet, provided he will apply himself to the work that is outlined for him in a conscientious manner. It is up to him to prove whether or not he is in need of hospitalization. Many men come to me in bad shape nervously, despite which they say that they can pull themselves up in their own homes. My reply to this is, "Fine. I hope you can. But if you find you cannot, it is then up to you to admit it, and we will make arrangements for you to go somewhere and get physically and nervously in shape." The purpose of this is twofold—to get the patient to act entirely on his own, and to allow him to determine his own degree of stability or instability. The man who cannot pull himself out of an alcoholic rut in his own environment, and who admits it, is in a position to benefit by institutional treatment without the resentment that usually results when out-

siders frighten or overpersuade one to go to an institution.

As I wish to keep my contact with the patient on a basis of friendship and mutual trust, I try to be entirely frank and honest in my approach. For instance, I tell him that I am going to instruct his wife, with his full consent, to let me know in case he has a relapse. I explain to him that this is not done because I feel that he will not be perfectly honest with me, but because a man who has started to drink and is in the throes of an alcoholic breakdown is not capable of acting in a mature or reasoning manner. I always try to keep the patient informed of the reasons for everything that has to do with treatment. In fact, I consider him more of a student than a patient—a student who has failed to pass the final entrance examination into a mature existence. It is up to him to gain insight as to why he failed and how he can succeed. There is only one thing that will prevent his passing this examination, and that is retaining the state of mind that sought an escape from reality in the use of alcohol. This is the reason why this psychotherapy has been an effective treatment in a great many cases of chronic alcoholism. It is well called reëducation, which is a word implying the possibility of a new and successful adaptation to life. For this reason, the insane and the imbecile must be excluded from the group who may be said to have a favorable prognosis.

If we accept alcoholism as a compulsion neurosis, psychotherapeutic measures at once suggest themselves, and we see that insight, reëducation, and readaptation of the personality must be brought about before the condition can be cleared up. This, I think, is the correct approach and one more hopeful and helpful than the defeatist stand so often taken, or the limited objective of keeping a man sober by any means that occur to an adroit mind.

The following quotation from Dr. Abraham Myerson, in his book, *The Psychology of Mental Disorders,* is of interest. He says: "The alcoholic's mental disease disappears with abstinence and there is nothing to distinguish him from other people except his reaction to alcohol." I beg to disagree. There are many things, besides his reaction to alcohol, by which he may be distinguished from other people. That reaction is definitely and recognizably abnormal, but so is the state of

mind back of that reaction. Peabody referred to the alcoholic's conflict in sobriety and pointed out that until this conflict—whether or not to drink again—is settled on a lasting basis, nothing of a permanent curative nature has taken place. Settling this conflict once and for all time is not the simple proposition that the many non-addicted seem to think. The man who has not experienced the state of mind of alcoholism usually has little realization of the bombardment of alcoholic impulses that besiege such a mind in periods of sobriety. Nearly every association of life has an alcoholic tie-up. Without alcohol the mental process is a painful one which the addict knows can be temporarily relieved by a reversion to his habit. The state of mind denied alcohol could be compared to a dull perpetual ache rather than an agony. I asked one man who had been off alcohol for three weeks before he consulted me how often the thought of drinking came up in his mind.

"It is much less now," he said. "I only average an alcoholic thought about every fifteen minutes."

The gesture of making a formal effort to give up alcohol creates an added mental conflict. Baudouin, in describing the difficulties of a patient overcoming a neurosis, used a very apt simile which I think is particularly applicable to the man undertaking treatment for alcoholism. He compared the neurotic to one who is learning to ride a bicycle. Ahead of him looms a large dangerous rock and, despite himself, he seems drawn toward it and usually comes a cropper on it. Probably we have all experienced this in learning to ride a bicycle, and we know that confidence and technique soon enabled us to avoid the rock. To the alcoholic the rock signifies drinking. He wishes to avoid it, yet seems irresistibly drawn toward it. Psychologically the job is to teach him to ride the bicycle and to show him how to avoid the rock, so that with a new technique he may learn to travel the pleasant road of reality that lies on the farther side.

To sum up the psychological approach to certain cases of alcoholism, the following methods of treating these cases have been of the greatest help to me:

1. Letting the patient convince me, and incidentally himself, that he is an abnormal drinker.

2. Allowing him to pick out his own alcoholic characteristics in Peabody's book, *The Common Sense of Drinking.*

3. Always taking the scientific psychological approach to the problem, which is usually welcomed as a relief from admonitions and emotional approaches.

4. Helping him to gain a psychological insight into his alcoholic problem and discussing his other problems with him during frequent appointments.

5. Instructing him how to relax physically and mentally and following this with suggestion while he is in a relaxed state.

6. Discussing alcoholic dreams. It is significant that every coöperative patient who has worked with me has, after a period of abstinence, experienced dreams of an alcoholic wish-fulfillment nature.

7. Giving the patient for exhaustive study some 80 notes by Peabody which he kindly allowed me to use in my work. These notes are of particular interest in that they cover and redirect certain trends of mind that inevitably occur to the man undergoing treatment. The vivid imagination of some of my patients has enabled me to add to these notes from time to time.

8. Mapping out a course of outside study so that it is interesting to the individual case.

9. Systematizing a daily routine which includes the keeping of a schedule, exercise, recreation, study, business, and hobbies.

The length of time necessary for adequate treatment is usually from 80 to 100 hours over a period of a year. With the beginning of treatment, two or three hourly appointments a week are necessary. Where patients are in hospital, daily appointments for several weeks, in conjunction with medical care, physio- and occupational therapy, and a scheduled existence, constitute an ideal beginning for treatment.

The major advantage of this form of therapy, however, is that it is carried on after the patient has returned to his environment. Here he has a chance to apply his newly learned psychological reapproach on the actual battle front, where the real test must take place. It is the adjustment in his environment with a sympathetic instructor that is the

most important phase of readjusting the point of view of the chronic alcoholic. The battle front is life, his life, with its sorrows and joys, perhaps complicated by a nagging or flirtatious wife, or domineering parents, a vicious business partner, or personal failures and successes, or just monotony and boredom. These are the offensive and defensive engagements that the partially rehabilitated personality must face. It seems reasonable that this can best be done with some one who understands the condition and who can discuss the problems of adjustments as they occur, in conjunction with the opening of the mind and reëducation along modern scientific methods.

The successful patient is one who realizes that alcohol is a mental poison for him, and who has learned, by repeated actual experiments over a long period of time, that the technique of facing reality is a far more pleasant and dividend-paying proposition than finding a miserable escape in alcohol.

TEACHING PSYCHIATRIC NURSING

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WHEN a nurse is assigned to a ward in a general hospital, she feels strange, but before long this feeling changes to one of comparative assurance or certainty in that she has a fair idea of what is expected of her. Unfortunately this is not true when she is placed on a ward in a mental hospital. Of the many reasons that might be given to explain the student's sense of insecurity in the latter situation, two that are significant are the incorrect ideas she brings to the work and the lack of established procedures.

Before we can teach the student psychiatric nursing, we may have to spend a long time tearing down her faulty attitude toward the study. Usually she shares with most people the idea that patients in mental hospitals are suffering from strange and hopeless diseases that affect the intellect and cause asocial and antisocial behavior. True, we have patients whose intellects are affected and we have patients whose behavior is asocial and antisocial, but these conditions are present in some cases only. In general medicine delirium is frequently observed, but people do not talk about delirium to the exclusion of all other conditions. And yet in the field of psychiatry the lay person and many nurses consider the occasional noisy and uncontrollable behavior to the rejection of all else.

Besides this general incorrect idea, the nurse frequently has additional wrong notions which she acquires while nursing. One of these is due to a kind of situation that is common in general hospitals. A student asks her head nurse what to do for Mrs. Brown, who is in pain. The head nurse suggests certain measures. Later the student again asks the same question, and so on. After this has occurred several times, the head nurse, finding her resources exhausted, exclaims in desperation, "Oh, forget it! She's spleeny," or

"It's in her head," or, "She's p.n." (psychoneurotic.) From any of these replies the student infers that the condition is mental and that the patient lacks grit and will power, that she could be different if she would, and, worst of all, that she really has no pain.

Another inaccurate opinion arises from the scale of wages set for private-duty nurses. Until recently the wage for nursing a mentally ill patient was one of the highest. Without question the nurse earned the money she received. However, the private-duty nurse is not called upon to take care of all types of mental sickness, but only of those in which the behavior of the patient is especially difficult. This tremendously important point is overlooked, and from the beginning of her career the nurse is led to consider a mental patient synonymous with a difficult patient. Over and over again nurses freely diagnose a patient as "mental" when the real situation is merely a bad disposition requiring tactful treatment from the nurse.

In the beginning, then, most of the student's ideas in this field are incorrect and they are so ingrained that one of our hardest teaching problems is to uproot them. The student is amazed when she finally appreciates the fact that in much of her psychiatric nursing care she is dealing with people who are not greatly unlike herself in thought and action and who are very much like her patients in general nursing, especially when she considers those patients in terms of personality. In this connection, a short orientation period in practice as well as theory is very helpful.

Most of our courses in psychiatric nursing have a definite didactic similarity. We all give material on the history of psychiatry, the etiological factors in mental disorders, the legal aspects, symptomatology, psychodynamics, the disorders themselves, the various schools of psychiatric thought, the means available in the community for the prevention and treatment of mental illness, social problems, psychometric testing, special therapies, and the nursing responsibilities in connection with representative types—the overactive, the inactive, the withdrawn, and so forth. It is the intention of this paper to omit consideration of the basal studies and to deal entirely with nursing care.

From the standpoint of instructive material, the psychiatric-nursing program resembles that used in general nursing. There is, however, one conspicuous point of difference. In the course of study for general nursing, the student is given some one hundred and twenty standard procedures for which we have no corresponding detail in our psychiatric-nursing syllabus. Is this significant? Frequently in general nursing we hear a nurse say, "I did not sit down all day," or "I have had a perfectly hectic day," or, "I have been so busy I have not had time to think." And when we ask her what she did, she will enumerate such actions as giving morning care, temperature sponge baths, hypodermics, enemata, applying turpentine stupes, etc.—in other words, a list of fixed directions. All her studies are necessary to give her a more intelligent understanding of her work, but in the last analysis the established procedure seems to be her tool or working equipment. When she comes to the psychiatric ward, with the exception of the wet-sheet pack and the continuous bath, she has had very little teaching through specific direction as to what to do and how to do it, and she is as a ship without a rudder.

In general nursing the temperature sponge bath given to John Doe is the same as the temperature sponge bath given to ten other John Does, and therefore is something that can be studied, at least in part, away from the patient. In psychiatric nursing we are not dealing with such things as a fever that can be reduced by bathing, or with flatus that can be removed by the right kind of enema; we are dealing with John Doe as a person, with his personal problems, and we nurse his opinions, passions, senses, likes, suspicions, and so on. We reach him through *feeling*. The course of conduct and the effects therefrom depend upon the nurse herself and her ability to handle well the situations that arise. The nursing care is by and through contact, and the nurse's groundwork for action is a delicate adaptation to personal feeling that can take place only as she is truly part of the situation. As the very heart of the situation, the personal feelings of the patient, is an unknown quantity, a unit of study that cannot be an objective item like a temperature sponge bath, but must be a personal appreciation of the patient by

the nurse. For this reason the work is individual and subjective, and it is the individualization and subjectivity that make the established procedure of limited use in psychiatry as an effective nursing method.

Examining our psychiatric courses for material that corresponds to the standard procedure in that it permeates the entire practical work, we find such items as encouragement, persuasion, ingenuity, reassurance, avoidance of argument, warmth of personality, good will, sincere interest, perseverance, endless patience, and so forth. These ideas are fine and solid when they are mastered, but after all they are rather intangible, vague, and abstract. And while the student is learning more than the dictionary meaning of patience, she continues to ask those of us who teach her, "What shall I *do*? What shall I *say*?"

In teaching psychiatric nursing we consider that the primary objective is to force the student to see the patient as a person and to deal with people by developing herself. With this in mind and presuming that the difficulty in reaching this goal lies in the individual, subjective nature of the study, we are using the following nursing methods at the Psychopathic Hospital of the State University of Iowa. The ideas are not new. They are being taught and used in general hospitals and, when given primary emphasis, seem to be effective in the psychiatric-nursing field. The material presumes that the administrator makes the teaching program possible and that the teaching ratio and the nursing-service ratio are as desired.

Progressive Observation Nursing Sheet.—This is an outline given to the student as a guide for the nursing findings in each new patient. Topics to the left of the sheet are as follows: ward, date, name of patient, temperature, pulse, respiration, diet, appetite, weight, medication, sleep, occupational therapy, gymnasium and recreation, hygienic habits, likes and dislikes, interests, special aptitudes, possible projects, conversation (safe and unsafe topics), general attitude and behavior, student's attitude toward the patient, problems, approach to problems with results.

At first the idea was a sort of work sheet for the head nurse to unfold in detail for the student. However, the develop-

ment of this material is the very experience the student needs, and so we have her record her findings from the observation of the patient, from information given by the supervisor, the head nurse, the social workers, the physicians, and other workers in the hospital, and secured from the hospital records.

Of the list of topics let us consider one item: likes and dislikes. For an example, when the student learns that Mrs. Brown prefers green tea to black tea, enjoys wearing a certain blue dress when her husband visits her, and dislikes lilacs, she makes it her concern to know that Mrs. Brown is given *green* tea, and does not have to ask for it; that the particular blue dress is in readiness and donned when the husband arrives; and that lilacs are not put into Mrs. Brown's room.

Appreciating that we tend to encourage the things that we like and to discourage the things that we dislike, the nurse makes a definite effort to find out the patient's likes and dislikes. With such knowledge she is less apt to do deliberately and unnecessarily things that irritate and disturb the patient and therefore bring about uncontrollable behavior. Isn't this what Clifford Beers meant in his autobiography, *A Mind That Found Itself,* when he said, having been asked what to do when a patient runs amuck, "Don't do anything to make the patient run amuck"?

While careful thought as to the patient's likes and dislikes is tremendously important in connection with the immediate behavior, there is a more subtle, but equally important item in the nursing care. This patient has failed in living and because of this he is experiencing a sense of injured self-regard. We tell the student to build up the patient's self-respect, and here are specific ways for doing it. We nurse through feeling. When Mrs. Brown is made comfortable by receiving the kind of tea she prefers or by wearing the dress she likes best for a special occasion, and is not irritated by lilacs which she dislikes, she is sure, *other things being equal,* to come sooner or later to the conclusion, "I can't be the worm I think I am. The nurses care. I must be of some account." When this takes place, successful treatment proceeds at a much more rapid rate.

The Progressive Observation Nursing Sheet brings forth

much equipment for nursing, but here time permits conclusions only. The developed material presents some interesting theoretical items such as the close relationship between physical health and mental health, specific problems associated with certain types of behavior, and so forth. But above everything else the student grasps the intensive, individual care of the patient. She is forced to consider detail and with it experiences the weight of trifles. She learns that the patient is not some one to be fitted into a scheme of hospital routine, but that she, the nurse, must suit the care to meet the patient as he is. In all, she learns that she must work much on herself and comparatively little on the patient. This is not a new emphasis for the student, but here it becomes a very real thing. The Progressive Observation Nursing Sheet gives her a structure on which to build nursing care, and while it is not an answer to our evident need, it does give the student a definite program of performance for immediate use and the instructor excellent material for discussion.

Questions Pertinent to a Situation.—If a student gives a patient a glass of milk and the patient drinks the milk, the nurse is happy. She has something concrete and objective to record—namely, 150 c.c. milk. Whether the patient was three minutes or three hours taking the milk, the record is the same. To indicate difficulty, very likely the word "uncoöperative" appears somewhere on the chart, but three hours of nursing care can be easily overlooked. Students readily see nursing in terms of results; we have to help them see it in terms of effort. Again, much of the difficulty seems to lie in the subjective nature of the study. What the nurse does and says influences what the patient does and says, and therefore the nurse has to bring herself into the situation. This fact is difficult for her to accept, especially if she is not successful, and we have to encourage her to the point where she fully appreciates that she fails only when she stops trying. We have her record her experiences, her conversation, and her own attitude as she deals with the patient whom she is nursing. Then we have her summarize her material, and to help her interpret and evaluate, we give her questions. For example, a student working on a case study had as one item of nursing care a difficult feeding problem, and to help her we gave her

twenty-four questions, of which the following were the last two:

> "As you studied the situation, did you watch for similarities? For example, to-day the patient ate a good breakfast; three days ago she ate a good breakfast; were there identical items in these two situations? Was the breakfast the same? Was there a relationship as to the amount of sleep the night before, the patient's mood on waking, the mood at the time, the hour of the day, the weather, the behavior of other people on the ward, the presence of physicians, an approaching examination, your own mental attitude, etc.?
>
> "Did you analyze the material and make a summary of the nursing care as to (1) effort, (2) negative results, (3) positive results?"

Pertinent questions can be used to help the student in working out problems (sleep, elimination, helping the patient become familiar with the hospital); they can be used in the observation of behavior (general attitude, stream of talk, projections, judgment, etc.); and they can be used in situations involving group activity especially in relation to social situations and the development of social consciousness in the patient. The questions are not general, but are made up for the special need or occasion. Always, the idea is to stimulate the student to see relationships and to think of ways and means of handling situations. Students find this thinking of new measures a fascinating game, especially when they finally experience achievement in direct relation to their own initiative and industry.

Compilation of Situations.—In this the student concentrates on a problem, and for a solution sorts out of her collected experiences, referred to in the Progressive Observation Nursing Sheet and Questions Pertinent to a Situation, all the experiences in which this problem arose. For example, if the student is dealing with the problem of insomnia, she considers separately all the situations involving insomnia of which she has had experience and makes a list of possible measures for its relief. From Mrs. A. she learned the need for attending to preventable noises; from Mrs. B. she learned the importance of her own approach to the patient in the matter of eliminating fear; from Mrs. C. she learned the possibilities in a back rub; and so on. However, this procedure is more than just making a list of ways and means. Being an inductive method of approach, it leads the student to recall not only the fact that a back rub, for example, may

be a successful way of getting Mrs. D. to sleep, but the associated experiences in the way of environmental changes and her own attitude in relation to success. All the while she carries on a vigorous effort to think of new possibilities, and before long she has an accumulation of resources much richer than she could have had if she had depended merely upon recall. The compilation of situations is an effort to get the student to use her own experiences in meeting present needs.

Development of Projects.—These are schemes for the student to work out with the patient and are aside from the prescribed occupational therapy. They are useful or interesting things that can be carried into actual living and are much the same as have been worked out by successful private-duty nurses. The student watches for potential interests in the patient and, using these as a cue, proceeds to introduce usable material which she gathers from the daily newspaper, magazines, and her contact with people. For example, if the patient is interested in fashions, a satisfactory type of project is to plan a wardrobe, scrapbook method. This requires special care and study on the part of the nurse. She should bring in such questions as how to plan a dress, how to make and judge design, how to select appropriate combinations of color, material, adjunct—why we do not wear pearls with sweaters, etc.

Other projects are making a bed, setting a table, dusting, ironing, arranging flowers, placing furniture, planning a trip, gardening, following the football news, the stock market, and so forth.

As a foundation for the development of projects, we give the students a few class hours in "experimental æsthetics," in which we deal with perception especially by feeling and consider such subjects as hobbies and the contribution of art to wholesome living.

Comparative Case Studies.—Psychiatric nursing lends itself well to the use of the comparative case study. For example, a study of catatonic schizophrenia and manic-depressive depressed psychosis, of two or more types of schizophrenia, or of manic-depressive depressed psychosis and manic-depressive manic psychosis brings out clearly similarities and dif-

ferences in nursing measures for different types of behavior —overactive, withdrawn, and so on. It also draws attention to particular problems in specific reaction types and to clinical material of significance and interest.

Use of Literature.—Using literature as an interpretation of life, we consider the characters as individuals. We analyze their habits, attitudes, thoughts, hopes, aspirations, struggles, conflicts, disappointments, reaction to difficulties, and consider the environment in which they live. We use three lines of development:

1. Books for study in mental hygiene. Here we give the student a list of novels from which she chooses one. She proceeds by picking out characteristics and experiences early in the life of the main character that influence the behavior later on. This is an idea that has been used for some time. A large number of books can be used in this way, and for a few suggestions we recommend Thomas Hardy's *Jude the Obscure,* Edna Ferber's *So Big,* and Arnold Bennett's *The Old Wives' Tale.*

2. Books for the significant biological, psychological, and sociological factors. These are selected and for an assignment we give the student a page or more of questions on the particular book to be studied. Some of the books that we use in this way are Flaubert's *Madame Bovary,* Tolstoy's *Anna Karenina,* Stendhal's *The Red and The Black,* and Dostoevski's *Crime and Punishment.*

3. Books related to formal instruction. Again, these are selected and we give the student a list of questions. Dostoevski's *The Idiot* brings out well the following subjects: epilepsy (subjective description of a seizure, objective description of a seizure, description of the depression following a seizure, and so on), alcoholism, showing clearly the accompanying degenerative changes, neurasthenia, physiology, pharmacology, psychology, sociology, mental hygiene, items of psychiatric significance, and items of nursing significance. Other books for the study of specific material are Shakespeare's *Timon of Athens* for general paresis and *King Lear* for senility; *The Closed Garden,* by Julian Green, for schizophrenia; *A Mind That Found Itself,* by Beers, and *Reluc-*

tantly Told, by Hillyer, for manic-depressive psychosis; *The Recovery of Myself,* by King, for drug addiction; and *Fear,* by Oliver, for psychoneurosis.

The study of literature demonstrates the universality of human traits, and the student finds so much in the material that is identical with what she meets in the hospital that she is obliged to appreciate the closeness of the patient in the hospital to the person outside of the hospital. This all helps her to see the patient as a person. Also, this method of study increases her knowledge of people and of ways of dealing with them, and, in addition, gives her a wealth of concomitant material in the way of items of general information and interest.

The response of the students is most gratifying. Early in the study they grasp the idea that the mentally ill are still human, that they feel, think, hate, love, have a sense of humor, respond to kindness, and so forth. Also, they soon learn that they are not dealing with diseases, but with reactions to personal problems shown in extreme emotional states, tangled imagination, resentment, impulsiveness, confusion, childish behavior, altered thinking, and so on, and that all of these conditions are quite like those observed outside of hospitals, only more pronounced. The nurse is not merely an observer. She studies phenomena with the clear purpose of a practical endeavor to alter them for the better. Her opportunity differs from that of the psychiatrist, for she is with the patient for hours together, and is not viewed by the patient as an observer, but as an understandable part of the environment. If the goal in teaching is to force the student to see the patient as a person and to deal with people by developing herself, we need to crystallize and articulate some basic concepts underlying our methodology in teaching nursing care.

THE MEDICAL PRACTITIONER'S OPPORTUNITY AND RESPONSIBILITY IN THE ADMISSION OF PATIENTS TO PSYCHIATRIC HOSPITAL *

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THE opportunity for a close working association with one of our large state psychiatric hospitals during the past months has forced upon the authors' attention a problem whose full importance had previously escaped us in the work at the Phipps Psychiatric Clinic—that is, the problem of the circumstances of admission of patients to mental hospital. One of the items of this study that is of general interest has to do with what the patient was told in advance concerning his entry to hospital. The authors very soon discovered that the casual question how the patient came to the hospital contained dynamite and resulted in much personal embarrassment. It was evident that the great majority of patients had not been properly prepared for admission to hospital by those immediately concerned with the commitment, and difficulties affecting the rapport arising from the unavoidable necessities of the change had needlessly been increased.

We thereupon began a systematic interrogation of patients on this question, excluding patients with defective memory. These records show that of 200 cases, 50 stated that they had received what might be considered adequate formulations, 45 inadequate, 33 false, and 72 none at all. That is, over 50 per cent had been given no preparation whatsoever for their entry to hospital.

* With some minor changes, as given at the Biennial Meeting of the Johns Hopkins Medical and Surgical Association, February 21, 1936.

The following excerpts from the records will show the variations from an adequate formulation to none:

"My family told me all about it before I came. I guess I needed to come."

"My son told me the name of the place and why I had to come. I feel better since coming."

Was told he was coming to the state hospital because he would not eat, and they would have to find out what was wrong.

Was told it was a place to go when you had trouble keeping your mind on anything. "I was having that sort of trouble, so I guess it was a good idea."

"Doctor told me she was going to send me to a nice place out in the country for a rest."

"They said I was coming to a place to be treated for my nerves, and I could go home after two weeks."

"They just put me in the car and took me here—didn't tell me anything."

"They told me they were taking me to St. Agnes Hospital. If I had known I was coming here, I never would have come."

An ex-nurse was told she was going to the hospital on a case and actually took her uniforms along.

"The sheriff come along and asked me if I wanted to ride to town with him. I'd often gone before and didn't have nothing better to do, so I just went along for the ride."

"They told me I was going to see my social worker."

"Going to a bughouse."

"Going to Johns Hopkins."

"Going to be examined for life insurance."

"Going to get my leg fixed, and can go home when it is well."

"My brother just put me in the car and brought me here. I didn't know where we were going."

"Two strange men came to my house and asked me to go for a ride with them. When I refused, they just brought me by force—didn't tell me anything."

"My mother said if I came out here, they would give me some money. I thought it would be a good idea if I came and got it."

"Going to a private hospital."

A patient with paranoid tendencies was told by her family that she was going to a court, where she could tell the judge the things she suspected.

"My husband said we were going for a ride. I had no idea we were coming here."

A woman whose son was a patient in the hospital was told she should go out to see him. When she arrived, she was evidently psychotic and was committed immediately.

All this, no doubt, is due rather to avoidable difficulties than to malice, but it is worthy of some constructive consideration. The common feature of it all rests on what we do with children and others who present specific behavior difficulties.

Three questions come immediately to mind in connection with this material:

1. In view of its origin from the patients themselves, is it valid?
2. What are the reasons for the poor preparation?
3. What difference does it make what the patient is told?

In regard to the first question, it is apparent, even with the exclusion of the data of patients with memory defect, that the truth of the data may be questioned on the grounds of prejudice and bias resulting directly from the patient's abnormal mental condition, whether from content or mood disorder. Such an objection is of less importance than at first appears (1) because experience shows it to be a safe rule to accept patients' spontaneous statements as true unless there is reasonable indication for caution and until they are proven wrong; and (2) because it is not the truth or falsity that counts in this instance so much as the patients' conception of what was told. The reasons for this discrepancy between the statements actually made and the patients' conception of the statements present a problem for further inquiry, now in progress. It may be safely said from the experiences at hand that one of the most fertile causes for this discrepancy lies in a faulty presentation of the material. It is reasonable to assume that some of the 36 per cent of patients who received no explanation whatever could have been given a workable formulation.

As to the second question—"What are the reasons for the poor preparation of patients for hospital admission?"—from an analysis of our 200 cases, to determine the agencies responsible for admission—family, physicians, and police—it may be said that no great differences were noted in the

manner in which this problem was met by these various agencies. The police are often used to transport patients to state hospital from private hospital, as well as from jail and magistrate's court. Of 84 cases brought to hospital by the police alone, 40 received no explanation, 14 false, 14 inadequate, and 16 adequate explanation. Of 14 brought by police and family, 5 received no explanation, 3 false, 2 inadequate, and 4 adequate explanation. It may be safely said that the error in handling this topic is general, and if the police have been singled out for special notice, it is only to call attention later to some constructive suggestions. The real causes of the trouble are the actual difficulties encountered, and the misguided effort to spare the patients through secrecy in the hope that the future course of events will justify the action taken.

As to the third question—"What difference does it make in any case what the patient is told?"—in spite of the rapid development in the past hundred and fifty years of mental hospitals to their present generally excellent standards, there remains in the thinking of many people a clear distinction between the psychiatric hospital and the general hospital. This distinction is born of the deep prejudices inherent in the age-old mind-body enigma, an enigma which scientific methods long ago resolved, but the new point of view finds tardy acceptance, not the least among our medical colleagues. The well-trained modern physician no longer asks this question.

The complete answer to the question as to the importance of giving the patient an adequate formulation of his problem lies in its bearing on the matter of psychiatric therapy. Therapy begins with the first contact with the patient, not merely after he has been safely lodged in mental hospital. A patient who submits to questioning by a physician deserves something constructive in return, and the physician who does not give it falls down on the job. A patient protested that he had been sent to hospital without being seen by a physician, having been lodged in a jail before admission. On detailed questioning of just what had occurred, he said: "Two men did look at me through the bars and asked me a few questions. I had no idea they were doctors." The physicians in this case obviously failed to fulfill their duty. This might be

regarded as an unusual example, were it not for the frequency with which somewhat similar stories are told.

Perhaps one of the strongest reasons for an adequate explanation is the effect it has on the patient's adjustment in the hospital. It is unfortunate that such a large percentage of patients are brought by the police, for this often gives the patient a wrong idea of the hospital from the start. He believes that being in the state hospital is like being in a jail and that he is being punished for something he may or may not have done. A patient who has been told that he is going to be examined for insurance, and who finds himself in a large institution with uniformed attendants and locked doors, is quite naturally likely to be resentful, and the hospital is immediately placed in a disadvantageous position. Rapport between the patient and the physicians and nurses, sometimes difficult enough to establish under ideal circumstances, is even harder when the patient has been lured to the hospital under false pretenses. This is especially true in the case of paranoid patients, many of whom assume that the physician and nurses are in league with those who brought them in. The embarrassment of the institutional psychiatrist when he meets with a patient who before entry has received an inadequate or false explanation, or none at all, is acute. He is placed in the position of an accomplice in the machinations of those outsiders who have brought the patient to hospital.[1] The issue, exemplified by the foregoing examples, is: How may the actual difficulties encountered in discarding the old and defective methods of "diplomacy" and secrecy be met? Diplomacy must be made the expression of a sound consideration of all the circumstances.

A survey of the same situation at the Phipps Psychiatric Clinic gave a more favorable result. In fact, it is very rarely that a patient is brought to that clinic without explanation of any sort. When a patient is brought there through subterfuge, the facts are taken up in open discussion by the admitting physician before the patient ever enters the ward. But

[1] Dr. Richard Dewey's treatment of the problem of establishing rapport between patient and institution should be remembered in this connection. See his "Some of the Means for Guidance Approach and Appeal in the Psychoses," and the discussions thereof by Drs. H. Ostrander and C. O. Cheney. *American Journal of Psychiatry*, Vol. 8, pp. 717–25, January, 1929.

that clinic for a number of reasons—not the least of which is that admission is voluntary—enjoys a rather special setting not shared by the large state hospitals. The advantages of voluntary private-hospital care are available to few. The care of the mentally sick long ago was recognized as a proper function of the state. The state hospitals are our hospitals, the responsibility of all, and peculiarly of the medical profession. They represent our opportunity and our responsibility to assure that steady development of the idea of a place for treatment, rather than for invidious social isolation.

Every medical practitioner will at some time, in some case, face the responsibility of initiating a move for psychiatric hospitalization. In most cases this will mean commitment to a state hospital. He can make of this responsibility an opportunity for initiating treatment by explaining to the patient the need for and the purpose of hospitalization in terms consonant with the situation, and making sure that the patient comes away from the interview with a reasonably adequate conception. This demands for its success a clear appreciation of the nature of the patient's difficulties, an equally clear idea of what is to be hoped for in hospital treatment, and a willingness to give to mental sufferers the same consideration shown physical sufferers. The task would be made much easier if physicians realized that by and large patients are willing to agree to, even to suggest, psychiatric treatment.

The physician can further help the cause of treatment by explaining the matter carefully to the patient's relatives, and by preventing them from giving inadequate or false statements to the patient. In this way he lays the foundation for that unity of effort through common understanding which is the basis of modern psychiatric treatment.

There will be great difficulties sometimes. The manner of, and the choice of opportunity for, presentation of the situation are important. The statement should be made as the consensus of medical and family opinion, and, in situations in which there is danger of violence or of suicide, at a time when action can be immediately carried out and with adequate help available to prevent the patient's thwarting the treatment. Perhaps the physician would prefer to rely on the experience of a psychiatric consultant for this task, but this does not

relieve him of responsibility, since he must be able to answer for calling on the specialized help.

Progressive medicine has favored the abandonment of the old jury trial for insanity and the substitution of commitment by physicians' certificates (subject always to the check of habeas corpus and jury trial) because it places the problem directly where it belongs—namely, in the category of public-health problems. Certainly entry to hospital should be carried out in such a way as to spare the sensitivities of patients and the patients' relatives. As things stand now, the commitment certificates amount to little more than an admission permit, since the relatives assume responsibility for the admission.

Because the matter is one of public health and hygiene, the wisdom of the widespread use of the police to carry out the actual admission is in grave doubt, unless an effort is made to acquaint the public generally with the function of the police in maintaining public health. The legislation on this point may be considered on a par with that on quarantine and health matters generally, based on police power.[1] To most people still, the police function only as crime deterrents.

Since admission to state hospital has purposely been made easy, it becomes absolutely imperative that those responsible for admission shall give patients and others interested no cause to assume that the privilege has been abused. It might be suggested, as a reform measure, that there be appended to the commitment certificates an obligatory statement of what was told the patient by the examining physicians.

It all reduces to the general formula that the modern physician must be willing to assume responsibility for the care and treatment of the individual at whatever integrative level trouble presents itself. Psychiatric specialism is a natural continuation of general biological and medical intelligence. It is not too much to hope that close coöperation may some day make psychiatric treatment vastly more effective. This coöperation has its effective beginnings in the adequate formulation to the patient of his situation by his own physician before he ever comes to hospital.

[1] For a treatment of this question, see: Adolf Meyer's "Modern Views and Propositions on Enforced Treatment for Mental Diseases." (*Maryland Psychiatric Quarterly*, Vol. 7, pp. 57–58, January, 1918.) See also "The Legal Aspect of the Commitment and Detention of the Insane," by J. S. Jones. (*Maryland Psychiatric Quarterly*, Vol. 7, pp. 59–77, January, 1918.)

FEEBLEMINDEDNESS AS A FACTOR IN TRANSIENCY

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TRANSIENT and homeless individuals have received little study from the psychometric point of view. A large number of surveys—principally qualitative in nature—have been published before and during the depression. Those of the pre-depression period were occupied mainly with the migrant's make-up as revealed by his mode of living. While this approach made colorful reading, it has not been of maximum theoretical or practical service. The literature of the last few years is somewhat more precise in its analysis, relying frequently upon statistical techniques to describe the problem.

While the more recent investigators, notably Schubert [1] and Webb,[2] have recognized the importance of the quantitative approach, their success has not been striking because, for the most part, their data lack interpretation and intercorrelation, and because they fail to relate their findings to the one factor that gives their groups homogeneity—that is transiency. Webb's results suffer principally because the socio-economic data are based mainly upon the transients' own statements, and he does not seem to give sufficient weight to the rather obvious possibilities of error. There is little material in his study derived from examinational rather than from interview techniques; thus all that we know about the transient's equipment and background is what he chooses to tell the intake interviewer. Schubert's study is somewhat better inasmuch as, in addition to the transients' own statements, he quotes results of medical and mental examinations. In his discussion of the intelligence level of his 651 subjects, how-

[1] *Twenty Thousand Transients*, by H. J. Schubert. Buffalo, N. Y.: Emergency Relief Bureau, 1935.

[2] *The Transient Unemployed*, by J. Webb. Washington, D. C.: Works Progress Administration, Division of Social Research, 1935.

ever, he does not record the median mental age, the name of the test used, or the circumstances of the test; and the social significance of the results is not considered.

The problem of feeblemindedness in transiency has not received the attention it requires. When the Binet tests were in the research stage, Knollin[1] investigated the intelligence level of a group of 150 California "hoboes," and, assuming sixteen years to be the mental age of the average adult, reported the incidence of mental deficiency among the migrants as 15 per cent. It is evident, however, that this figure has little pertinence for the present-day group of transient unemployed in view of the changed economic conditions which, in turn, have added to the selective factors in transiency.

With regard to the incidence of feeblemindedness in the general population, recent investigators[2] have agreed in placing the number at 1 per cent, or, roughly, 1,200,000 in this country. It is the purpose of this study to evaluate the extent to which mental deficiency is a problem in the present-day transient group as compared to the population as a whole.

The data of the present report were obtained in July, 1935, from a carefully chosen sampling of New York City's male, non-resident population. At the time of the study, 7,700 transient men were on relief. Of these, a group of 504 were selected for study. For each client, socio-economic information was available from his intake-interview card, and, in addition, his mental-test score on a thirty-minute group intelligence examination (the Hennon-Nelson high-school test of mental ability), given with adequate motivation under fairly favorable conditions. The "typical" transient was found to be 37.9 years of age, single, native white, a former resident of an urban Eastern community, an unskilled workman with elementary-school education, unemployed since February, 1932, and transient since July, 1934.[3]

[1] Quoted by L. Terman, in *The Measurement of Intelligence.* Boston: Houghton Mifflin Company, 1916. p. 18.

[2] See "Community Control of the Feebleminded," by E. Doll. *Annals of the American Academy of Political and Social Sciences,* Vol. 149, pp. 167–74, May, 1930. See also "Eugenic Sterilization of the Mentally Unfit," by E. Whitney. *Medical Journal and Record,* Vol. 129, pp. 696–98, June 19, 1929.

[3] The group differs from that Schubert studied in Buffalo principally in that his group's median age was 29.98. Webb's estimate likewise places the

Table 1 gives a distribution of the group according to mental-test scores. It will be noted that there is a concentration of cases on the lower intelligence levels, and that the average mental age of 12.14 indicates that the group tends to be of dull mentality.[1]

TABLE 1.—I.Q. RANGE* IN GROUP OF 504 UNEMPLOYED, NON-RESIDENT MALES, NEW YORK CITY, 1935

I.Q.	*Number*	*Per cent*
56– 61	79	15.7
62– 67	70	13.9
68– 73	75	14.9
74– 79	87	17.2
80– 85	64	12.7
86– 91	22	4.3
92– 97	21	4.2
98–103	20	3.9
104–109	26	5.2
110–115	21	4.2
116–121	19	3.8
	504	100.0

Average I.Q. 75.9. Standard Deviation 16.86
Average M.A. 12.14. Standard Deviation 2.70

* Average adult intelligence taken as 16.0.

Table 2 gives a comparison of this finding with three authoritative estimates of average adult intelligence—that of Terman,[2] that of the study conducted by the University of Minnesota Employment Stabilization Research Institute,[3] and that of the army.[4] It appears from this that the transient group is distinctly below the average.

median age between 27 and 30. It is thus apparent that those transients who registered in New York City for relief tended to be considerably older than the average for other parts of the country.

[1] When the educational factor is held constant by considering only those cases which completed seven, eight, or nine years of schooling, the average mental age and variability in test score is the same.

[2] Terman, *op. cit.*

[3] *Manual of Selected Occupational Tests for Use in Public Employment Offices*, by H. Green, I. Berman, D. Patterson, and M. Trabue. Minneapolis: University of Minnesota, 1933. Vol. 2, p. 73.

[4] *Psychological Examining in the United States Army*, edited by R. M. Yerkes. (*Memoirs of the National Academy of Sciences*, Vol. 15.) Washington: Government Printing Office, 1921.

TABLE 2.—AVERAGE MENTAL AGE OF TRANSIENT GROUP AS COMPARED WITH THREE ESTIMATES OF AVERAGE ADULT INTELLIGENCE

Study	*Date*	*Average adult mental age*
Terman	1916	16.0
Minnesota	1923	14.4
Army	1917–19	13.9
Transient group	1935	12.2

The amount of feeblemindedness depends upon the criterion used. It is generally conceded that I.Q. 70 is the upper limit of mental deficiency. If the Terman estimate is taken as the normal, the transient population is 37.7 per cent mentally defective; if the army criteria are employed, 12.7 per cent are in the feebleminded category.

Table 3 is an analysis of the problem from the racial point of view.

TABLE 3.—PERCENTAGE OF FEEBLEMINDED IN THREE RACIAL GROUPS AMONG 335 TRANSIENTS *

Group	*Number of cases*	*Per cent feebleminded by Terman criterion*	*Per cent feebleminded by army criterion*
Native white	212	35.4	6.5
Foreign born	77	42.8	20.8
Negro	46	69.6	41.3
Total	335	38.7	12.7

* Information on this point was not available in 169 cases.

It is pertinent to inquire qualitatively into the social adjustment and background of some representative cases of mental deficiency in the transient group:

Case 1: Jim Harrison, forty-three, mental age 7 years, 8 months, native American, transient for the last five years, wanders about the country with "my pal." He has never been involved in delinquency, but has been the dupe of unscrupulous employers. At present he is working for 75¢ a week, and is completely contented with this. He cannot care for simple personal needs, is unable to dress or to shave without some assistance. He is illiterate except for the ability to print simple words like "cat," "rat," "cow," etc. He spends his spare time at movies and burlesque shows and "reading" the pictures in the tabloid newspapers. Occasionally he obliges friends by acting as a passive homosexual. Blood Wassermann is positive.

Case 2: Dennis McIntyre, fifty-eight, mental age 6 years, born in New York, applied for transient relief after being arrested for street begging. He is married, but deserted his family two years

ago. He is chronically alcoholic and almost entirely illiterate; he cannot spell his own name. He lives by casual labor, begging, and occasional petty theft. He has no special recreational or social interests, and has little insight into his situation. He is beginning to show psychotic symptomatology related to alcoholism.

Case 3: Fritz Schmidt, twenty-six, mental age 10, is of German stock. He was referred for relief by the police. He is unstable vocationally; has several industrial injuries. His peak earning capacity was $14.00 weekly. He became transient after a quarrel with stepmother five years ago. His physical health is good, but he is beginning to evidence neurasthenic symptoms.

Case 4: Jimmy Baker, nineteen, mental age 8 years, 8 months, left home in 1930 after his mother's death and quarrels with his father. He wandered about the country, living by occasional delinquency and casual labor. He was in reformatory once. His physical health is good. He is bullied by boys and men in transient shelter. He has recently taken to smoking marihuana cigarettes.

The data presented would seem to indicate that feeblemindedness is an important background factor in transiency. It has been observed that, according to the army standards, the transient groups studied contain twelve times as much mental deficiency as the population as a whole. It is recognized that all feeblemindedness cannot be defined entirely in terms of mental-test score, and further that not all clinical feeblemindedness is necessarily an institutional problem. The extent to which the individuals studied require custodial care obviously cannot be discovered without individualized investigation, but the cases quoted indicate that even when institutionalization is not required, these boys and men constitute a rather serious social problem.

Lacking supervision and other adequate social control, the mentally retarded, transient unemployed are likely to drift into delinquency, mendicancy, sexual perversion, emotional instability, and possibly even psychosis. What is required is competent social supervision, vocational guidance, training, and placement, as part of an individualized clinical and social program.

THE VALUE OF DETERMINING REALITY ADJUSTMENT AS A MEANS OF ESTIMATING FLYING APTITUDE *

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FOR a number of years the routine examination of applicants for flying training in the Air Corps of the United States Army has included a study of the methods of reality adjustment employed by these applicants. The psychological mechanisms rather arbitrarily designated for study are those of sublimation, rationalization, projection, phantasy, and symbolization, either singly or in combination.[1] There is in addition a stipulation that it be determined whether either extravertive or introvertive tendencies predominate.

It is essential, prior to a discussion of the value of determining "reality adjustment" as a means of estimating flying aptitude, that the mechanisms of reality adjustment be gone into, at least superficially, in order to arrive at a conception of the meaning of the term. It would be absurd to intimate that such a subject could be discussed with any degree of completeness in a short paper, for in a broad sense reality adjustment implies the sum total of the psychobiological reactions of an organism to all exogenous and endogenous stimuli. The behaviorists devote their life work to this study.

The newborn human being must be regarded as an organism not completely integrated. The behavior repertory of the newborn infant consists of a relatively large number of simple, discrete, specific reflexes and a limited number of specific patterns of response. The postulation of an initially chaotic, unorganized complex of behavior is no more satis-

* From the Department of Neuropsychiatry, School of Aviation Medicine, Randolph Field, Texas.

[1] United States Army Regulations 40–110, C2, December 15, 1933.

factory than is the assumption of a high degree of specificity in early activity. Regardless, however, of the theories of infant reactions and regardless of our concept of development, we must admit that the structural bases of generalized and specific behavior is already present and that reality adjustment begins as soon as the child leaves the uterus. Without an attempt at explanation of the intricate evolution from simple infant reactions to complicated psychobiological adult adjustments, it should be obvious that a comprehension of adult methods is impossible without such a postulation. Adult reality adjustments are founded upon the infantile pattern, though modified so greatly by environmental experiences and complexity of requirements as to obscure this fact from common observation.

Thus in adult life, as in infancy, we find behaviorism, which is reality adjustment in a broad sense, to be a continual process of getting to or getting from a goal object or situation; that is, reality adjustment is the process of avoiding undesirable situations or objects and of attempting to obtain desirable situations or objects.

On the basis of the individual's ability to attain such situations or objects, his satisfaction with and reaction to nonfulfillment, his means of substitution, and in fact even his perception of reality, we attempt to classify individuals as to their methods of reality adjustment. By observation of an individual when a craving is thwarted, by determination of his ability to tolerate such thwarting, his ease of surrender, his adjustments by direct attack, his adjustments by introversion or imagination, projection, rationalization, and so forth, we attempt arbitrarily to classify him. Thus we state that the individual adjusts to reality by sublimation, rationalization, phantasy, projection, or by other means. These are not exactly classifications, in as much as one individual may adjust by several means. However, we do attempt to index the individual according to the method or methods most commonly employed.

The question that now confronts us is, What is the value of such a determination as a means of estimating flying aptitude? Of what importance is reality adjustment in life in general? Does the individual who adjusts by pure sublimation attain success more frequently than he who rationalizes

or indulges in phantasy? Perhaps the correct answer is that indulgence in phantasy, projection, and these other psychological mechanisms are a hindrance to attainment depending upon the proportion of psychobiological energy expended in them.

Contrary to what one might expect, we find that practically all outstanding individuals indulge in phantasy and projection, and to some degree in rationalization. Thus we find phantasy indulged in not only by those who lack the energy or the ability to reach easily attainable goals, but also by those whose goals are constantly beyond reach. Phantasy in these latter individuals is utilized further to stimulate the individual until attainment of the goal is possible. Rationalization in such individuals is utilized only to maintain pride and self-esteem until achievement is possible.

Thus in using a determination of indulgence in these mechanisms as an index to possible attainments, it is more important to determine the proportionate energy expended in them than their actual existence in the individual. In doing this we have no sounder basis for our opinion than an evaluation of past achievement.

Unfortunately, we know all too little regarding flying aptitude and what constitutes it. However, common sense tells us that rationalization and phantasy are of little help to the pilot, at least while in actual flight. While on the ground, failure of attainment may be made tolerable to the individual by such mechanisms, but while in the air judgments must be promptly and accurately made if the pilot is to live to fly again. This fact should require little emphasis.

It was thought that some insight into this question might be gained by a study of a number of cadets and student officers who had entered the Air Corps Training Center of the army. A study of 538 such students revealed that 266 graduated, 267 failed to graduate, and five were killed in crashes. Of the 266 graduates, 52 per cent were considered introverts and 48 per cent extraverts. Sixty-seven per cent were thought to sublimate with or without other methods of reality adjustment. Thirty-nine per cent were thought to use rationalization, 0.4 per cent projection, 0.7 per cent phantasy, and 1.5 per cent other mechanisms. Of the 267 non-graduates, 32 per cent were extraverts and 68 per cent

introverts. Seventy-five per cent were thought to sublimate with or without other methods of reality adjustment. Forty per cent were thought to use rationalization, 1 per cent projection, 4.1 per cent phantasy.

The group of five that crashed was too small to carry much weight, at least on a percentage basis.

It will be noted that 52 per cent of the graduates were considered introverts, while 68 per cent of the non-graduates were so considered. Looking at it from a different angle, we find that of a total of 318 introverts, 138, or 43 per cent, graduated. In contrast to this we find that 48 per cent of those that graduated were considered extraverts, whereas only 32 per cent of the non-graduates were so considered. Thus we see that of a total of 215 extraverts, 128, or 60 per cent, graduated. This would appear to indicate that extraverts have a better chance of completing flying training than have introverts. The question that we cannot answer is, How much was the better showing of the extraverts due to the effect of the extraversion on flying aptitude and how much to the better impression made on the instructors by the extraverts? We must remember also the conditions of the training environment. The extravert's probably better adjustment among the students may influence his adaptation to the entire course. Certainly his ease in making friends and in adapting to life is no hindrance to him.

The only other observations worthy of note are that out of the four who were thought to indulge in projection, only one graduated, and that of the thirteen who adjusted by phantasy, only two graduated. Certainly this might indicate that projection and phantasy, to the extent of being determinable, are not desirable methods of reality adjustment in flying cadets. (There was practically no difference between percentage of rationalizers in the graduate group and the percentage in the non-graduate group.)

The question which should be raised is, Did phantasy and projection in any way influence flying aptitude or may it not be that perhaps the applicant is poor in judgment who admits indulgence in such things to any great extent to the psychologist who examines him? There are few individuals who do not indulge in both phantasy and projection, but these are some of the things that most individuals do not feel are the

concern of others. All humans, even those of accepted normality, turn at moments to their private sanctuaries for refuge from facts they cannot face. These sanctuaries are part of the inner life which most are hesitant to reveal. Also, it may be considered that instead of phantasy and projection being detrimental in themselves, they indicate, if indulged in to any great extent, a general inefficiency of reality adjustment if the individual is forced to rely upon them.

It would seem from this study of a representative group of students that the methods of reality adjustment used are of little importance in estimation of true flying aptitude, but that they may be of greater importance in estimating adaptability to training life as a whole. We are of the opinion that the important thing is the efficiency of reality adjustment rather than the methods employed. That again brings us back to the hypothesis that our best method of evaluation of future performance, which depends partially upon reality adjustment, is on the basis of past achievement.

THE VALUE OF A PLAY GROUP IN A CHILD-DEVELOPMENT STUDY*

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A CHILD playing with other children frequently acts differently than when observed in company with his mother, his family, or alone. One gets an incomplete picture when relying only on personal interviews with parents and children in the clinic or home.

In studying the physical, mental, and emotional development of a group of forty-seven infants and children[1] and in a reported case study,[2] all of the data were obtained by interviews and observations as described above. As an adjunct to the continued study of the forty-seven children and their siblings, a group play hour was established because, in a play session, one can observe a child's adjustment to a person in authority, to playmates, and to materials. The adjustment to one in authority sheds significant light on the child-parent relationship. It has been shown from psychoanalyses of children and adults that factors of child-parent relationship are transferred from the family circle to the outside environment. Similarly, sibling relationships are reflected in the child's attitude toward his playmates in school and elsewhere. This being the case, the physician can use overt behavior as shown in a play group to throw light upon family relationships. Play-group observations can be utilized as adjuncts to psychiatric examinations just as laboratory tests are for physical examinations, but in neither case can they replace

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[1] See "Formation of Character as Observed in the Well-Baby Clinic," by M. E. Fries, K. Brokaw, and V. F. Murray. *American Journal of Diseases of Children*, Vol. 49, January, 1935. p. 28.

[2] See "Interrelationship of Physical, Mental, and Emotional Life of a Child from Birth to Four Years of Age," by M. E. Fries, M.D. *American Journal of Diseases of Children*, Vol. 49, June, 1935. pp. 1546–63.

the specialists' examination. The danger of all such procedures and short-cuts is that they will be substituted for the more difficult one of interviewing parents and children, which requires a greater amount of experience and time. The tendency during periods of financial depression is to employ the "short-cut" method, as it is difficult to pay for the specially trained physicians. Both methods, however, are of value when used to supplement each other.

The play group during clinic hours was a great incentive to the mothers to return regularly for treatment. While the children were at play, the mothers gathered in a group; this weekly meeting helped them to realize that there were other parents seeking aid for their children's emotional as well as physical development. This is a great advantage, as it reduces the feeling of guilt which many parents harbor in regard to the emotional life of their children. They often feel inadequate if they cannot rear their children without psychiatric advice. This feeling of guilt often keeps parents from asking or accepting aid in directing the emotional development of their children, whereas they have a totally different attitude when seeking aid for physical ailments. Here they do not hesitate, but on the contrary feel it is their duty to ask the doctor for help.

The play group made coming to the hospital enjoyable not only for the mothers, but for the children also. The latter knew that either before or after the interview with the physician, there would be a play hour. Naturally, when both parent and child enjoy attending the clinic, follow-up work and treatment are facilitated. Furthermore, the insight gained from such a group, conducted by an experienced kindergartner and recorded by clinically trained observers, adds considerably to the understanding of each child's behavior.

Weekly, monthly, or bi-yearly physical examinations by the pediatrician were given and interviews by the psychoanalyst were held with the children and the mothers. The frequency of clinic visits depended on many factors, such as the seriousness of either physical or emotional conditions, the distance of the home from the hospital, the coöperation of the parents, and so forth. Besides complete physical, psychiatric, and psychological examinations conducted at the hospital,

home visits were made by case-workers trained in psychoanalytic principles.

A one-hour play group was conducted on the same morning as the clinic. (The time was later expanded, whenever possible, to accommodate late-comers). On sunny days, the children played in the courtyard and during inclement weather, indoors. The parents were not permitted to be present unless a child, during the first hours of attending the group, showed anxiety over the separation from his mother. As long as was necessary, in such instances, the mother sat near by. Otherwise parents gathered elsewhere or were occupied with interviews with doctors. When it seemed advisable for the mother to see her child's adjustment to the group, she was able to do so from a nearby window without being seen.

The kindergarten teacher in charge and the observers who recorded were thoroughly familiar with the psychoanalytic theories of child development. Their work was carefully supervised by the psychoanalyst and consequently was closely integrated with the rest of the research. A great deal of free play, plus some directed play, gave the best opportunities for observing the adjustments of these children. Hospital conditions (routine and noise restrictions) necessarily placed certain limitations upon desired freedom, but even with these handicaps, valuable observations were made.

Such observations, as an aid in understanding children's behavior, must be recorded by a clinically trained observer. She must know the significance of the interacting factors; otherwise she will see only superficial, overt, and general behavior, which adds no new data to the case history. In this study, the behavior and attitudes of the child were studied in relation to other people and objects. Special attention was focused on situations which brought out the child's response when he was either deprived or indulged, such as his reactions when another child took his toy away, or when he was chosen leader in a group play or given special privileges. These deprivations and indulgences were not purely physical in nature, but psychologic as well. For example, when a mother leaves her child in the play group, this is, for a normal child,

not only a physical separation, but also an emotional experience—namely, the loss of the loved person. Again, when a child is excluded by other children from the group, this is normally experienced as a serious deprivation, while the approbation and love of the other children is experienced as an indulgence.

Two types of observation were employed—group and individual. There are advantages to both methods and the two taken together, when this is possible, give the most satisfactory results. Group observations give a picture of the entire environment to which the child is responding. Furthermore, his behavior can then be compared with that of the rest of the group and any deviations will stand out. The individual observation allows for a more detailed study of actions, reactions, and attitudes. In this study, two observers recorded simultaneously—one the group activity and the other the child who was being specifically studied at the time.

The following reports of three children indicate how valuable this play group has been in supplementing the data obtained from physical and mental examinations and psychiatric interviews. These three cases were chosen from the larger group studied because they present either typical cases or interesting variations.

Robert—A Well-Adjusted Child.—Robert, who is now four and a half years old,[1] has a sister two years his senior. His parents appear to be well-adjusted and highly intelligent, the father teaching in a private school. The child's physical, emotional, and psychologic development has been completely satisfactory from the parents' and the doctors' points of view.

The first time Robert came to the play group, the case-worker introduced the child, his mother, and his sister to the kindergartner, who invited the two children to join the group. Robert waved good-by to his mother, walked away from his sister, and immediately entered a game of bean-bag-toss with two other children. Although his mother left the yard, he played the entire hour without crying or asking for her and later willingly left the group with the psychologist, who took him indoors for a mental test. At another session, several weeks later, a toy cash register was presented to the children, none of whom could fathom its use. Several of the group gave up trying, two shook the toy angrily, and three asked to be shown how it worked. Robert announced,

[1] This and the following case reports cover a six-months period of attendance at the play group. Robert, therefore, was only four years old when he first attended.

"I know how it goes. You do this." He not only succeeded in manipulating the toy, but patiently demonstrated it several times to the others. During subsequent play-group sessions, his social and emotional adjustments were equally excellent.

In this case, play-group activities bore out the description of the home behavior as reported by the mother, the case-worker, and the physician.

Jimmie—Whose Mother Complained Primarily of His Physical Condition (Malnutrition).—Jimmie, who is now four years old (he was three and a half when he first attended the play group) is the first and only child of American Catholic parents. At birth, he sustained a facial paralysis from a low forceps delivery, at which time the mother rejected the child. The paralysis cleared up after five days. He suffered from severe rickets from three and half months of age and had numerous colds. His dentition was slow and he was considerably underweight.

His feeding problems (refusal of food) started at five months of age when he was breast weaned, according to his mother. He was bottle weaned at thirteen months. His appetite was always poor and he never chewed his food, eating only puréed food. The father also is a fussy eater. The mother is a compulsive neurotic, "disgusted" at the child's feeding habits and poor health. The home is pleasant, but in a neighborhood that is becoming populated by Negroes. The mother objects to the neighborhood, but is forced to continue living there because the maternal grandmother owns the house. The grandmother, who also lives there, joins with the parents in worrying over Jimmie's feeding difficulty.

With the exception of this difficulty and the frequent colds, the mother claimed that she was satisfied with the child's development. On further investigation, she said that while he played well with other children, he would run to her and complain if the boys teased him, but she did not consider this significant. This, however, was the first indication to the psychoanalyst that there might be a poor social adjustment. The following excerpts from the observer's notes on Jimmie's behavior in the play group substantiated this surmise and indicated that treatment was necessary:

First visit to play group.—Jimmie began to cry as his mother prepared to leave him. He cried, "Want Mama!" He insisted on being taken to his mother, who was with the psychiatrist, and refused to leave her when she brought him back to the yard. He stood with her during the remainder of the session and did not speak except to whine, "Mama," if she walked away. He did not join the group.

Second visit, one week later.—Jimmie's behavior was similar to the last week's. He still did not join the group.

Third visit, one week later.—Jimmie played in a circle game with the group for three minutes before crying for his mother. He then left.

Fourth visit, two weeks later.—Jimmie spent twenty minutes watching the group from behind a bench, with his right forefinger in his mouth the entire time. He refused, as in other sessions, to drink milk, crying, "I want Mama!"

Fifth visit, one week later.—Jimmie was the only child remaining

standing during a sitting game, but participated for five minutes in a group ball game.

Sixth visit, one week later.—Jimmie remained with his mother, smiling at the other children. His mother said, "Go ahead and play." Finally he joined the group, but followed his mother when she left.

Seventh visit, one week later.—Allowing his mother to leave, Jimmie remained alone on the bench. Ten minutes later, he played with Tom, (a hyperactive child described in the following case report) and drank milk for the first time with the group. He dropped his cup, at which Tom said, "Sit down, Jimmie. I'll get it."

Eighth visit, one week later.—During a group circle game, Jimmie yelled and laughed, but usually failed to catch the ball because he extended his arms before or after the ball was thrown. Harry, another child, cried, "I want my Mama," at which Jimmie pointed to him, saying, "He wants to go to his Mama."

Ninth visit, one week later.—Jimmie drank all of his milk although first insisting that half be emptied. He stayed with the group the entire hour and was most coöperative.

Tenth visit, one week later.—After drinking his milk, Jimmie got a paper bag, put his cup in it, and smilingly held the bag for Tom's cup. Tom blew a horn at Jimmie, then patted his head. Jimmie continued to smile.

During the following sessions, Jimmie continued his friendly and coöperative behavior, although he usually refused to try solving any of the problems presented (new toys to manipulate, and so forth) and always asked for assistance until two months later when he persevered at hitching trains together until the task was accomplished without help.

During the fifth month of attendance, Jimmie's return to his former behavior (clinging to his mother) was noted in the play group, although his mother had reported no changes at home. However, these play-group observations made us independent of the mother's report in ascertaining changes in the child. Since we were able to detect the regression in behavior to an infantile stage sooner than the mother would have reported it, we were more easily able to ascertain and treat the cause.

After six months' attendance at the group, the kindergartner's report of Jimmie's behavior states: Although not a leader, Jimmie is one of the most active members of the group and has helped to organize a "baseball team." He refuses to play with the girls and seems to like quiet play with blocks and trains. He is the first to ask for milk and eats crackers without dipping them first in the milk. (Cf. history of eating only puréed food). The doctor's report shows Jimmie's present gain in weight to be the first appreciable one in several years. The case-worker says he is increasingly active and friendly, while the mother reports marked improvement in appetite and feeding, as well as fewer colds.

The play-group observations in this case showed that Jimmie's dependency and attachment to his mother was so great that he had difficulty in adjusting to her leaving him. He reacted to this deprivation by withdrawing from the world. No matter how much attention the kindergartner gave him,

he could not be compensated for what had been taken away. Not until he could find another person with whom he could associate did he stop playing alone. It was interesting that a very hyperactive and unadjusted child (see description of Tom cited below) made friends with him and became his hero. Jimmie imitated him, followed him around, and played with him, but not until some months later would he play coöperatively with the entire group.

It was significant that the prototype of Jimmie's reactions to life's frustrations was to be found in his reaction to weaning at five months of age, when he became passive, negative, and withdrawn from the world. At that age, he had apparently experienced weaning as a severe psychologic trauma.

The value of group therapy for less seriously maladjusted children has been well established. In this seriously maladjusted child, there was ample opportunity to determine the value of either group therapy for the child or psychotherapy for the mother—or both methods in combination. At various periods of time, there was neither a play group nor a psychoanalyst's time available for this case. Therefore, it was purely by chance that each method was tried out separately. The results from these separate methods were unsatisfactory because either the mother or the child lost interest. When, however, group therapy for the child and psychotherapy for the mother were combined, Jimmie's emotional development progressed satisfactorily along with his physical improvement.

Tom—A Hyperactive Child Whose Parents Consider His Development Satisfactory.—Tom, who is now six years old (he was five and a half when he first attended the play group) is the only child of American, Catholic parents. The latter's marital history is a stormy one, the father having left the mother several times. On one occasion, he took the family furniture and went to live with his parents, making it necessary for Tom and his mother to live with the maternal grandparents. Although divorce was contemplated, it was never carried out because of financial and religious considerations. At present, the tension is considerable owing to the fact that neither parent will give the other grounds for complaint because legally the offending party can be held liable. Tom's father is on Work Relief earning $24.00 a week.

Tom's life at home has been insecure because, in reality, he has had two homes—one with his maternal grandparents and another with his parents. He had his crib and toys at the maternal grandparent's apartment where he spent much time because, as the mother claimed, his father says Tom "messes up the house with toys." The father also

cautioned Tom not to dirty furniture or clothes. His mother admitted that the child had never had much freedom at home. Because of his father's restrictions on the one hand and the maternal grandmother's devotion to the child on the other hand, Tom has spent most of his life with the latter. Consequently, his life has often been interrupted by changes from one home to the other, although the major portion of his time has been spent away from his parents' home.

His previous health history includes a normal delivery, eczema at five months, rickets at eight months, urticaria at ten months, chronic enlarged tonsils and adenoids, and strabismus since two years and ten months. For the latter condition he now wears glasses, and it has caused him much anxiety. He is very sensitive to other children's jibes and criticism, reacting by being very aggressive toward them.

After six months in the play group, the kindergartner reported as follows on Tom's behavior: "Tom is overactive and continually races around the yard purposelessly, kicking gravel. He delights in getting dirty, and is usually disobedient. He is selfish, prefers playing alone, teases other children, and freely expresses dislike of others. When thwarted or scolded, he blushes and begins to choke."

Since Tom's behavior has been fairly consistent during all the play-group sessions, it is sufficient to present a typical observation of him as recorded in the following excerpts from the fifteen-minute group report of a session during his fifth month of attendance. Five children were present, excluding Robert and Jimmie, previously referred to in this report.

Excerpt from play-group observation.—While Miss G. [the kindergartner] was indoors collecting toys, Tom picked a leaf from a shrub. When Miss G. returned, Janet (a four-year-old girl who upon her mother's request is receiving psychotherapy for hysterical vomiting and aggressive behavior) said, "Miss G., Tom picked a leaf."

Tom: "She's a tattle-tale."

He took a whistle from Janet, who said, "You'll get a disease from somebody else's mouth." Tom dropped the whistle, picked up a toy bunny, and spanked it viciously.

Janet: "Look, he's taking everything!"

Tom: "Miss G., she takes all my things."

Dorothy, aged four and a half, who always plays alone, picked up her own pocketbook and ball and throughout the session refused to let any one play with the ball, saying, "My mother says I have to keep it clean." She sang to herself for ten minutes, refusing to join the group. Tom picked up a hammer and flung it repeatedly at the toy box, finally breaking the latter.

Miss G.: "Where will we put the toys when it rains?"

Janet: "We can't play because the rain makes the toys damp."

Tom glared at her silently, ran across the yard, slammed the door shut, and looked at Miss G. defiantly.

Miss G.: "We keep that door open, please."

Tom reopened it, returned, picked up the hammer, and hit Janet with it. She said, "He's hammering me!" Tom stopped and picked up a piece of wood, asking, "Is this a gun?" He hammered it violently four times, then dropped it.

The kindergartner was forced to direct the ensuing play because the

group became too noisy for the hospital. She suggested playing ball, to which Janet replied, "He [Tom] wants to play with the hammer."

Tom: "I want to play with Dorothy's ball."

Dorothy hid her ball beneath her dress and Miss G. asked, "Why did you bring your ball?"

Dorothy: "So I can play alone."

During the ensuing group ball play, Dorothy sat alone and Janet took the racket, preparing to hit the ball when it was thrown by Miss G. Dorothy picked a piece of gum from her pocketbook and chewed vigorously. After Janet had been unsuccessful in three attempts to hit the ball, Tom grabbed the racket from her, swung around, and hit the racket against a tree, laughing loudly. He then picked up a stone which had been loosened from the base of the tree, saying, "Somebody broke this."

Janet: "You did."

Tom: "I did not."

During the next four minutes, the directed play included Miss G.'s throwing the ball in the air for all to try to catch. Tom ran around wildly and continuously, letting out wild whoops when any one caught the ball. He finally retrieved it, threw it so high it brushed a tree, and shouted hilariously, "The ball grew up in the tree!"

At the kindergartner's suggestion that the group play follow-the-leader, Tom said, "I don't like to play that game." He stepped out of the formed line as did Alice (a quiet child of the same age who generally plays alone). During the game, Tom watched the group intently while Alice sat next to him playing with the pebbles on the ground. She finally poured stones on his shoe. He smiled, and did not remove his foot, but immediately picked up a handful of pebbles, threw them at the marching children, looked furious, laughed loudly, ran to a corner, whirled around, returned, and resumed his place next to Alice. Then he said to Miss G., "I'll hit you on the head some day, maybe."

Miss G.: "For what reason?"

Tom: "I like to see it. I don't like to play. I'm afraid of marching."

Alice continued sitting on the bench absorbedly playing with her shoe. Tom also sat there nodding his head in rhythm to the clapping of the marchers. Neither child on the bench paid attention to the other. As soon as the marching ended, Alice jumped quickly off the bench, ran to Miss G., and stood quietly looking at her. She then picked up a toy, looked at it, and put it down again. Janet, seeing this, remarked, "She don't play with nothing."

As Miss G. left the yard to get milk for the children, Tom shrieked, "Milk! I'm going to drink milk! I like to stay here alone—no people to mind." He picked up the hammer, hit a board, then threw both away. Alice laughed softly while watching this. Tom repeated the actions three times, looking at Alice each time and continuing after she had laughed. The fourth time, when she failed to laugh, he scowled, picked up Dorothy's ball, and threw it into the bushes. He then picked up a paper carton, tore it to pieces, and threw it at Alice, who backed away. He next picked up a toy bunny and spanked it severely.

Janet (to recorder): "Tom don't want me to have the bunny."

Tom: "Take the other one."

He picked up a train, looked at it, and gave it to Alice, saying, "Should we bust it?"

Alice: "Santa Claus won't bring any more."

As Dorothy came toward him, Tom sat on the one bunny, saying to Alice, "You sit on the other one and don't let her [Dorothy] have it." Alice hid the toy under the front of her dress, lifting it high as she did so. Tom immediately picked up a toy toilet, ran to the fountain, filled the toilet with water, and brought it back to Alice, saying, "Look what I made for you." Alice did not respond, and Tom ran back to the fountain, looked into the bowl, and shrieked, "The boat's drowning!" While the children drank their milk, Tom began a singsong chant which finally resolved into "Cups on the bups, cups on the nups." He suddenly stopped to say to no one in particular, "I seen a blinded man with a stick. A kid brought him across the street." He rubbed his eyes under the glasses and appeared frightened. Then he jumped up, shrieked, ran for the bunny, picked up Alice's dress, and looked for the second bunny which she had previously hidden there. He finally found the toy on the ground after which he rubbed the bottom of both bunnies together and laughed as the toys squeaked. He continued rubbing them together, yelling, "Boomp! Boomp! Bunnies make boomp!"

Tom's behavior in the group was so totally different from what had been expected according to the mother's statements that it threw considerable light on the child's actual development. The play-group activity also made it possible for the doctor to discuss Tom's asocial behavior with his mother, who up to that time had denied any problem in social adjustments.

His hyperactivity was an expression of his great anxiety. He was in constant fear of his parents. In this case, the mother's leaving him was not experienced by the child as a deprivation, but as an indulgence, as shown by his remark, "I like to stay here alone—no people to mind." However, his anxiety returned whenever a child or the kindergartner thwarted him. He consistently refused to play follow-the-leader, saying, "I'm afraid of marching." His anxiety was so great that, on the one hand, it kept him from certain forms of play while, on the other, it forced him into overactivity. The exact etiology of his anxiety could not be ascertained just from observing group play, but merely gave indications as to the nature of his difficulty, and could be uncovered only in individual psychologic interviews.

In Tom's case, the play-group observations gave important material that was entirely different from that obtained in the usual interviews and home visits. In an easy and quick way (his mother and the doctor observed Tom in the play group

from the window) the topic of the child's social maladjustment could be presented and discussed with the mother. As soon as she was able to face this serious problem, which she had hitherto tried not only to conceal, but also to deny, it was possible to institute psychotherapy.

SUMMARY

A play group of one hour a week was instituted in connection with the Research Clinic on Child Development. The data obtained supplemented, but did not supplant the rest of the findings, which were collected from home and clinic visits, physical and mental examinations, and psychoanalytic interviews.

A play group in connection with a child-development study may serve many purposes, depending upon how it is conducted and observed. Specific benefits of such a play group (not only for study, but also as an adjunct to a clinic) can be:

1. To furnish an added incentive to both children and parents to return to the hospital for follow-up work or treatment.
2. To furnish a direct means for learning about, but not the etiology of, the child's adjustments:
   a. To companions of his own age and to a person in authority.
   b. To deprivations and indulgences.
3. To gain insight into the validity of the mother's reports and to furnish a check on the case-workers' observations.
4. To give an indirect insight into family relationships.
5. To point to the steps necessary in future therapy.
6. To obtain, through group activity, some therapeutic results.

BOOK REVIEWS

RESEARCH IN DEMENTIA PRAECOX; PAST ATTAINMENTS, PRESENT TRENDS, AND FUTURE POSSIBILITIES. By Nolan D. C. Lewis, M.D. New York: The National Committee for Mental Hygiene, 1936. 320 p.

Most " research " volumes have come to the reviewer as finished products. The present work is a novelty in that it is rather a program than a finished product — a promise of work to be accomplished, suggestive indications of important areas that are in need of intensive investigation, recapitulations of much that has been done as a foundation for future elaboration.

Apart from all this, the source of the stimulus is of special interest. It comes from the Supreme Council of the 33° Northern Masonic body. It is a pleasing indication that one of the greatest disasters of the human race — dementia praecox — should receive such particular attention from a body of layman as to lead them to finance this research through The National Committee for Mental Hygiene. As a product of an enlightened democracy, their action is highly commendable.

Still further, the choice of the leader in this enterprise merits our attention. It is testimony of the broad-minded nature and coöperative spirit of Dr. William A. White, of Washington, that he permitted his right-hand man to engage in this most needed of expeditions. And finally the profession has, in the person of Dr. Lewis, an exponent of more than average caliber, and one from whom much may be expected.

With the preliminary character of this 320-page work in mind, a glance through its pages opens up a broad vista of important enterprise in psychiatric research. General principles are emphasized; detailed study is to follow. As a preliminary, Dr. Lewis deemed it wise to look over the field, and above all to investigate the mental tools available for the study in men and in equipment. This necessitated a round of visits to hospitals, general and special laboratories, men and scientific groups, to gather first-hand knowledge of what was the actual attitude of workers most concerned with the difficulties. Here monistic tendencies were not considered as most desirable. Ancient traditions linger in psychiatry as in other medical fields and, because of the special complexity of social behavioristic activities, seem to be more unwieldy than in less complex fields. The need for

coördination of different trends of interest in psychiatric workers was evident.

In a foreword Dr. Lewis reviews these and other special difficulties in a highly informing and intelligent manner and then builds a platform of present-day attainment, looking toward the completion of his goal. This platform consists primarily of an analysis of the work already accomplished, chiefly of the bibliography of the past fifteen years, during which time some 1,800 papers have become available. This literature is analyzed as a preliminary to discussion of the special modes of attack.

Then follows a discussion of clinical aspects of the subject. How may "dementia praecox" be defined, delimited, and described? This is an essential plank in the platform, and the present chapter prepares it in an exemplary manner. Dr. Lewis is not committed to one type of tool in the fashioning of this plank, the result being a well-outlined bit of framework. An extensive bibliography arranged by years — not as useful as if arranged by special content — completes this chapter.

The problem of etiology takes up the next chapter. Here again the survey is quite satisfactory. We miss Kraepelin's anthropological observations on dementia praecox, but as they lie outside of the fifteen-year period this is understandable. A little more on dementia praecox in twins might have been included.

Constitutional morphological features are analyzed in Chapter IV. Here the type problem is ably set forth and the present-day aspect clearly outlined. Dr. Lewis' own extensive observations put him in a favored position to accent important aspects in this field. Electroencephalography, myogram research, endocrinological features, neurochemistry, biochemistry — all these are touched upon pertinently and provocatively.

Differential diagnosis is then taken up. Here the border lines between irreversible somatic processes and psychoneurotic reversible processes are analyzed and some relevant case-history material is utilized to illumine the discussion.

Finally we have a chapter of conclusions, which is made up chiefly of a plan for procedure in psychiatric research. This we must leave to the individual reader, with the assurance that it is well worth while.

This volume is highly welcome. It is admittedly provisional and experimental, but with this insight and this mode of approach one can rest assured that something more than a mouse will come out of this mountain.

New York City. SMITH ELY JELLIFFE.

THE NERVOUS PATIENT: A FRONTIER OF INTERNAL MEDICINE. By Charles Phillips Emerson, M.D. Philadelphia: J. B. Lippincott Company, 1935. 453 p.

This is a very comprehensive book dealing, as Chapter 1 states, with "many latest organic diseases; the major psychoses, in their mild forms and early stages; unusual cases of epilepsy; various behavior problems which rest on physical troubles; and, especially, the neuropsychoses."

We must admit that this is a considerable undertaking. From the point of view of writing an inclusive medical work, Dr. Emerson has succeeded admirably and has certainly called attention to the relation between soma and psyche in a way that should be of real value to many who are practicing medicine. Such emphasis on the total situation is in accord with the most modern medical teaching and again should serve a useful purpose for many medical students.

As this review is designed for a publication read largely by those in the practice of psychiatry, no detailed discussion of the book will be attempted except from the angle of the psychiatrist. A psychiatrist cannot but feel that the author is a bit arbitrary when he states there is no such disease as psychasthenia and no such disease as hysteria. We realize fully that some of the classification of the psychoses and psychoneuroses has been largely symptomatic, but we cannot help feeling that the same applies to general medicine, in which not all diseases are classified directly according to etiological factors. Certainly hysteria and psychasthenia are still included in our classification of diseases and in standard textbooks on nervous and mental disease.

As we go on in the book, still looking at it from the point of view of the psychiatrist, we are a bit distressed to find that many of the statements are scarcely to be considered in accord with the most recent thought. For example, those of us who have long since seen restraint given up in the best mental hospitals could hardly subscribe to the statement, on page 191, that the "delirious pneumonia patient should always be restrained." Again, on page 199, in the discussion of the treatment of delirium tremens, it seems a little superficial to remark that "some recommend spinal drainage and alkalis by mouth to combat the nervous symptoms," instead of stating when spinal drainage is indicated and why. Again, in the discussion of disturbances within the sex life, we find a very marked tendency to neglect some of the accepted understanding of these conditions as related to the unconscious motivation of the individual.

The book is so good in many respects that the reviewer cannot but

regret that, when it deals with disorders of the nervous system, it should not be better. Perhaps I can illustrate what I mean by referring to a paragraph on page 269 which deals with the complex of inferiority. Here we find the statement that the individual suffering from an inferiority complex under certain circumstances "suffers a complete nervous breakdown" (whatever that may be). We certainly should feel that if we are to discard hysteria as a disease, we should not in a medical treatise talk about "complete nervous breakdowns," as it has for a considerable period of time been thoroughly realized that a "complete nervous breakdown" is the layman's term for everything from acute alcoholism to timidity.

In the chapter on the psychoses, we regret to find, under the treatment of the manic-depressive psychoses, the statement that warm packs are not to be recommended since they suggest restraint. Perhaps the author's lack of familiarity with mental motivation is best indicated when he states, as he does on page 413, that "no attempt should be made to probe the mind of the depressed patient since such study may lead to suicide." At this point the psychiatrist cannot but wonder how many suicides would have occurred had the attempt not been made to reach a better understanding of the mental mechanisms of the depressed patient, instead of letting him go on carrying within him a cause which for lack of treatment might later lead to suicide.

The neurologist as well as the psychiatrist will, I fear, be somewhat disturbed when he reads of various neurological conditions, the understanding of which in this volume can hardly be said to be in accord with the most modern neurological thought. Take, for example, the statement in the discussion of Mongolism that the "cerebrospinal fluid of these cases often does, however, precipitate colloidal gold in the syphilitic zone." On this subject I have not looked up the older literature, but I know from the experience of most of us who deal with this condition that such a general statement is hardly to be treated as important evidence.

The purpose of this book is excellent; the material is very comprehensive and much of it is extremely well presented. But when it deals with the psyche rather than the soma, it is unfortunate that the references are not more up to date and that the generally agreed upon psychological tenets are not given more consideration.

ARTHUR H. RUGGLES.

Butler Hospital, Providence, R. I.

1934 Year Book of Neurology, Psychiatry, and Endocrinology. By Hans H. Reese, M.D., Harry A. Paskind, M.D., and Elmer L. Sevringhaus, M.D. Chicago: Year Book Publishers, 1935. 782 p.

This volume, which presents in abstract form the selected publications of 1934, maintains the high standard of its predecessors. The foreword informs us of the retirement from editorship of Drs. Bassoe and Ebaugh and of the addition of the section on endocrinology.

The section on neurology is admirably handled by Dr. Reese. He feels that two outstanding contributions in 1934 were "(1) Maurice Brodie and Arthur R. Elvidge's experiments in poliomyelitis, which established the neurogenic distribution of the virus from the nasal cavities over the olfactory nerves into the central nervous system; (2) William F. Petersen's studies on mental and nervous diseases. The meteorological, seasonal, and geographic investigations in relationship to clinical manifestations of various disorders have opened new channels for scientific interpretation, not only from a physicochemical, but also from a pathologico-anatomical point of explanation." Encephalitis is thoroughly reviewed and discussed, after which one finds the report of the completion of studies on the St. Louis epidemic. The present status of the luetic problem is given, and we find that little progress has been made in this field in 1934.

Dr. Paskind, editor of the section on psychiatry, states in his foreword that "the psychiatric literature of 1934 is voluminous." He has succeeded in extracting from this voluminous mass those articles which indicate the progress of psychiatry in that year. The traumatic neuroses are discussed and articles are presented which stress the niceties of diagnosis and treatment of a somewhat poorly understood entity. Central-nervous-system conditions due to excessive alcoholic intake are studied, but one notes that no mention is made in the literature of 1934 of the importance of the avitaminotic factor in Korsakow's syndrome.

The third section, on endocrinology, edited by Dr. Sevringhaus, is very valuable because it brings order into a field which is new and somewhat chaotic to the clinician. The editor hopes that his presentation will help the physician to a better understanding of the subject of endocrinology and will enable him to diagnose and treat glandular disorders in a more rational manner. Before the literature is presented, the editor outlines very concisely the current ideas of the interrelationships of the glands. He calls attention to an outstanding article by E. Grafe (Wurzburg), which discusses the relation of the endocrine system to heat economy. Numerous articles are presented on the subject of thyroid-gland disturbances. Much work has been done on the subject of parathyroid-gland dysfunctions,

and a plea is made for recognition of these disorders, because therapy in hyperparathyroidism is "highly successful." Another outstanding advance in the year's work is that on the adrenal cortex and its interrelation with the anterior pituitary. Wilder's paper on the anterior-lobe pituitary extract in the treatment of Addison's disease is presented, as are numerous other enlightening works on this subject.

This review of the year's literature clearly shows the progress made in 1934 in the three branches of medicine in question and indicates the attitude and approach that characterize these fields both here and abroad. Medicine has become a vast and somewhat unwieldy subject. We must thank the editors of this volume for making available to us so much material in such well organized and readable form. Besides the abstracted articles, there are discussions by the editors of various subjects of interest, illustrations, and a complete subject-author index.

JOHN EVANS.

Colorado Psychopathic Hospital, Denver.

PSYCHOPATHOLOGY. By George W. Henry. Baltimore: William Wood and Company, 1935. 312 p.

In the preface of this book the author states that it was written "primarily for medical students and members of the medical profession . . . a presentation of the nature and causes of personality disorder, together with a description of methods of examination."

The method of presentation is essentially clinical, and one gets the impression throughout of an assiduous avoidance of systematization. Were it not for the fact that the subject matter is so involved and so loosely scattered through so many fields of scientific endeavor, one might consider this avoidance a defect. The book, however, gives to medical students and physicians alike a candid picture of the present status of psychopathology. It is factual rather than theoretical. It asks more questions than it answers and is, therefore, stimulating to the serious student of the subject.

As a whole, the book should be useful to teachers of psychopathology. It has many practical aspects and with generous supplementation could be utilized as a text. There is an excellent chapter on brain function, and considerable space is devoted to methods of examination and the taking of histories. There is a fairly good index and a short bibliography.

The point of view throughout, however, is strictly medical. Little or no attempt is made to evaluate the significance of social forces, cultural patterns, or educational experience in the broader sense. This is a psychopathology born out of hospital wards and out-patient

clinics. It has little to do with children and adolescents and adults as they are to be found in everyday life. One would like to see written a psychopathology that might be more useful to the educator, the social case-worker, the clergyman, and to many a physician in general practice. For them this book will not do.

R. A. JEFFERSON.

Milwaukee Mental Hygiene Council.

THE MARRIED WOMAN. By Gladys H. Groves and Robert A. Ross, M.D. New York: Greenberg, Publisher, 1936. 278 p.

It will be observed that this book is addressed to the married *woman*. This is significant. Although the reviewer knows of no statistics that have been collected on the subject, he is inclined to believe that most books on how to be happy in marriage are far more widely read by women than by men. The reason for this is not far to seek: women have a greater stake in marriage than men. For the man, marriage is usually "a thing apart; 'tis woman's whole existence." Those who have had clinical experience with unhappy marriages can bear out the observation that generally it is the wife who shows most concern over the state of domestic affairs. How to get her husband to take more active and intelligent interest in the marriage is a common query with which wives come to the marriage clinic. Yet, interestingly enough, although women are wrapped up in their marriages as men are not, the success of a marriage in our culture depends upon the husband even more than it does upon the wife. In our culture, the man is indicated as the leader in the relationship between the sexes. No one has developed this idea more ably than has Wilfred Lay in his stimulating book, *A Plea for Monogamy*. We have, then, in our culture, the curious contradiction of the husband as the one who is supposed to take the initiative in family experience and give it direction, and the wife as the one who is actually very much more concerned about it. The big problem of marriage would seem to be, then, one of how wives can educate their husbands. This book by Mrs. Groves and Dr. Ross, even in its title, recognizes this fact.

The Married Woman is a straightforward, practical guide to happiness in marriage, written for the general public. Upon what does happiness in marriage depend? Given a wise choice of mate, clearly the most important remaining factor is the kind of person one is. Another way to put it is to say that generally the most wholesome people make the most successful marriages. The central asset is a healthy and mature emotional life. In the reviewer's opinion, no book of

advice is adequate which does not stress this fact. Information on such matters as sex technique, pregnancy, household management, and budgeting is valuable to have, but there is little probability that it will be assimilated by individuals who, in addition to being ignorant of these things, are also deficient in their emotional make-up. It can be said to the credit of this book by Mrs. Groves and Dr. Ross that they recognize this fact and make the psychological factors the core of their emphasis. Chapter I, for example, gives attention to personality difficulties — such as fixation, narcissism, and guilt feelings — that handicap a woman in getting married satisfactorily. Chapter II considers the importance of developing right attitudes before marriage toward such matters as chastity, masturbation, health, and career. Chapters III, IV, V, and VI look into some of the psychological factors — such as worry, haste, and fear — that affect sex adjustment in marriage. The rest of the book is largely given over to problems connected with childbirth — the right to have children, when to have children, the experience of pregnancy itself, contraceptive techniques, including the safe-period method, and so forth. The book closes with a discussion of certain mental-hygiene aspects of the menopause.

Readers of *The Married Woman* can have special confidence in the reliability of what they find on the printed page, because of the nature of the collaboration. Back of the physiological and medical materials stands a noted physician, Dr. Ross, who is a member of the obstetrical and gynecological staff of the Duke University Medical School; and back of the psychological material stands the name of Groves, which needs no introduction to students of mental hygiene.

M. F. Nimkoff.

Institute for Family Guidance, Bucknell University, Lewisburg, Pa.

Objective and Experimental Psychiatry. By D. Ewen Cameron, M.B. New York: The Macmillan Company, 1935. 271 p.

In his introduction the author of this book points out that because the general beliefs of an age tend to promote only those concepts which make for their own survival, it is necessary to examine the effects our beliefs may be exercising upon our fact-gathering in psychiatry and to apply as far as possible self-correcting, self-criticizing quantitative and experimental methods in this field. The comparatively late development of psychiatry results in our finding ourselves still very largely in the subjective, observational phase, with relatively slight progress in the direction of quantitation and experimentation, and many of the observations in this field have been rendered of

dubious value by the following factors: (1) the tendency in gathering facts to depend too largely upon retrospective accounts by patients or relatives, subject to all the errors of memory plus those of subjective and selective questioning; (2) the tendency of the observer to ascribe to the patient the feelings and thoughts that it is considered he should be entertaining in a given situation (what the author calls "projectionism"); (3) the tendency of the worker to conventionalize in terms of already delineated concepts ("conventionalization"). The result of these factors has been that our etiological concepts are largely restricted to proximal situations which might provoke psychic pain, the intensity of which then is taken as an indication of the activity of the nocuous stimulus; whereas in reality psychic pain (like physical pain) may well be not at all proportional to the importance of the nocuous agent—may indeed be absent in some of the gravest situations for so long a time that events coincident with its manifestation would give no lead as to what the active agent was or when it began to act.

There are many difficulties in the way of quantitation and experimentation in psychiatry and as yet we remain dependent in large part upon the more subjective observational methods for an approach to therapy. Nevertheless, there is a small, but growing body of workers who are applying themselves to these problems and who have already accumulated a sufficient number of authentic quantitative and experimental techniques and results to justify an attempt to bring them all together in one place. With this introduction in the first two chapters, the author sets out on this attempt.

The material in the various fields is reviewed under the following chapter headings: *Tests of Intelligence; Introversion-Extraversion; Word-Association Tests; Conditioned Reflexes; Heredity; Statistics; Blood-Sugar Tests; Response to Ephedrine and Adrenalin: Haemoclastic Crisis; Respiratory Center and Schizophrenia; Epilepsy; Basal Metabolism; Blood Pressure; Sedimentation Rate, Haemato-Encephalic Barrier and pH Relations to Personality; Constitution; Pathology;* and *Statistical Methods.* The material from the literature is reported accurately and under most circumstances completely enough to give one at least a fairly satisfactory idea of what quantitative and experimental methods have been able to reveal in regard to these various topics. A few of the chapters seem to the reviewer inadequate; for example, under *Tests of Intelligence,* there is a rather conventional discussion of the Binet-Simon test and the calculation of the I.Q., with the usual warnings as to its interpretation in the light of disturbances at the lower and the higher functional levels, but there is no discussion of the tests for special abilities which psychiatrists have found useful in the vocational guidance of young pa-

tients who are being returned to society. The reviewer recognizes that such tests are serviceable only when they reveal limitations that would preclude adaptation to a special vocational field, but in this respect they have been found immensely useful and certainly merit some discussion. Again, under *Blood-Sugar Tests,* in discussing epilepsy the author makes the statement: "In epilepsy there is as yet lacking convincing evidence to show that there is any change in the sugar metabolism which might in itself be causative of convulsions." In demonstrating this he uses statistical studies and blood-sugar tests made on epileptics as a group. He makes no mention of the work of Seale Harris and others who have demonstrated that there is a group of convulsive disorders associated with hyperinsulinemia and at times with tumors of the Islands of Langerhans some of which have been controlled by proper attention to carbohydrate diet or by appropriate surgical measures.

The organization of the book does not appear entirely logical. For example, in the chapter on word-association tests there is a minor section on psychoneurotic tests which attempt to reveal neurotic tendencies by questionnaire methods and which are not logically to be grouped with the purely word-associational experiments. It seems to the reviewer also that it would have been better to have grouped all of the pharmacodynamic reactions together instead of dealing with some of them in connection with other matters as is done in the present volume.

In spite of the faults mentioned above, the volume is very well worth while. It undoubtedly represents a tremendous amount of work and it could scarcely be expected that a first attempt in this direction would achieve perfection. The volume is distinctly useful. Its discussions of statistical methods, of the problem of heredity, the psycho-galvanic response, the conditioned reflex, etc., are soundly critical, and the bibliography is complete enough to be of service to any one interested in any of these fields of research. The book will undoubtedly be received with general approval, and it is to be hoped that there may be a second edition in which some of the faults of the first will be corrected.

LAWRENCE F. WOOLLEY.

The Sheppard and Enoch Pratt Hospital, Towson, Maryland.

THE ANATOMY OF PERSONALITY. By Howard W. Haggard, M.D., and Clement C. Fry, M.D. New York: Harper and Brothers, 1936. 357 p.

A simple and coherent presentation of a concept of personality from a structural-analytic point of view is no easy task. However, Drs. Haggard and Fry have achieved this end in a refreshing and

very readable manner. While the authors acknowledge the eclecticism of their background, they lean most heavily on the contributions of Eugen Kahn. In essence, the major theme is that of a popularization of Kahn's concept of psychopathy.

The publishers have done remarkably well with the book. It is in large print, well paragraphed, and illustrated in an amusing and stimulating fashion. The authors have borrowed the illustrations of four characterological types from the English translation of the *Characters of Theophrastus.* The book consists of six parts whose titles are quite as striking as the illustrations: *The Manners of All Men; Realities That Lie in the Flesh; Freedom That Grows with the Mind; Bondage in Moods and Emotions; The Meek, the Mild, the Militant; The Streams of Life.*

After a vivid presentation of the "vulgarian" as described by Theophrastus, the authors raise the pertinent question whether or not the descriptive method is valid for the evaluation of human personalities. They feel that the method is fallacious in as much as not personality, but character is described; further, that Theophrastus dealt with composites—*i.e.,* the behavior of certain personalities when placed in a specific setting. Their own interest, the authors state, is primarily with the personality itself. They discuss the inherent difficulty of the problem, the nature of the two variables—behavior and environment—and the constant—personality. Their approach utilizes the method of structural analysis. The basic elements of the personality—physique, impulse, intelligence, temperament, and ego—are enumerated. The method is then applied to the "vulgarian" of ancient Athens, revealing that personality as possessing a strong impulse, an active, but cold temperament, an egocentric ego evaluation, an average intelligence, and pyknic physique. This synthetic product is then placed in various and varying environments and his behavior predicted.

Approaching the question of the relationship between physique and personality, the authors arm themselves with a "cautious attitude against making too direct and sweeping inferences." In their summary of Kretschmer's results, they introduce to the lay public the terms "pyknic" and "leptosome."

This relationship leads them to a discussion of physique and disease—including brief expositions of manic and schizophrenic behavior and finally of types illustrated by means of historical and other figures, not least among which is the leptosomic cheer leader who succeeded in making an ass of himself.

Proceeding from a chronological account of the biological evolution of the human body and personality and incorporating the fundamental strata of personality in their progress, they discuss character.

Annoyed at the well-wishing child psychologist, educator, and parent, they feel that the personality is not wholly plastic; moreover, that the fundamental qualities of personality cannot be altered, but that their display can be modified by character formation.

Accepting the Kahnian concept of "experience" and an individual's "way of experiencing," they feel that character is formed only as the fundamental strata of the personality will permit it to be formed in the particular setting in which it is placed.

A simplified interpretation of the concept of psychopathy and some of its manifestations, the psychoneuroses, is offered. Intelligence, the quality that has so long monopolized the interest of educators, is thought to be less causally related to deviated personalities than the quantitative variation of the remaining strata of the personality. A wish is expressed that education might incorporate a method of structural analysis of personality in furthering more logical guidance, heeding the limitations of the personality.

Parts IV, V, and VI present in a somewhat abbreviated and simplified manner Kahn's chapters on "psychopathic personalities considered from the points of view of temperament, character, and impulse." They are spiced with excerpts of graphic case histories which are entertaining as well as instructive.

Finally, to demonstrate the practical application of the method of structural analysis, a complex psychopathic type is presented. For this purpose the hysterical person is chosen and his peculiarities are analyzed. The authors, in presenting the method of the structural analysis of the personality, conclude that an evaluation of the endowment of the personality must necessarily preface any planned character formation. This, they state, and no more, is the scope of their book.

The principal value of the book, it appears to the reviewer, is the establishment of an objective and scientific attitude. A deluge of quasi-popular literature has sprung from the beliefs of sociologists who have overstressed the influence of environment and the plasticity of the personality. The sick people who have read those books have been a prey to the thousand and one dull and harmful platitudes that have been offered to them. The meek have been intimidated; the hysterical have found novel and varied symptoms; the militant, fortunately, probably have never read them.

One can safely recommend this entertaining and informative volume to all. It gives one an understanding of a method of analysis of one's endowments, and thus of one's capacity to live.

JOHN ROMANO.

Colorado Psychopathic Hospital, Denver.

THE SINGLE WOMAN AND HER EMOTIONAL PROBLEMS. By Laura Hutton, M.D., with a foreword by David Forsyth. Baltimore: William Wood and Company, 1935. 151 p.

Dr. Laura Hutton, a London psychiatrist, has written an excellent discussion of the problems that beset the single woman. The problems are presented so clearly that not only single women, but all others will be able to understand them.

Too often, the single woman has been a figure of fun and as such has been widely satirized. However, the tiny band of idle old maids has recently become a large body of active, intelligent women, playing an indispensable part in the life of society. The author feels that these women have not received consideration in the recent flood of literature on the emotional and sexual adjustments in marriage. "There are at the present time," she says, "large numbers of more or less independent single women of mature age who earn their own living, and make a big contribution to the life more particularly of our cities, as doctors, schoolmistresses, secretarial and clerical workers, welfare and social workers of all kinds, not to mention many others in responsible positions, for whom the prospect of marriage, though not necessarily extinct, is nevertheless not to be counted on, who have at least to be prepared to live out their lives as best they may without any natural adequate fulfilment of their normal physiological function as women."

The Single Woman is Dr. Hutton's attempt to provide some sort of counsel and aid to help these women solve their problems, usually more complicated than those of married women. There are five chapters: *The Single Woman To-day; Emotional Friendships and Some of the Psychological Problems Involved; Sexual Problems; Sexual Inversion;* and *Adjustments.* A sane, common-sense, and adult point of view has been adopted by the author in her discussions of these topics. She stresses especially the necessity "for an *adult* conception of personality," and her ideas concerning solutions depend upon the necessity of avoiding infantile and adolescent behavior. No panaceas are offered, because the problem is individual for each woman, but stress is laid upon a wide divergence of interests and acquaintanceships.

There is much thought and a great deal of wise counsel in this small book, and no intelligent, self-supporting woman can read it without gleaning something of value for herself.

WILLIAM F. MENGERT.

University Hospitals, Iowa City, Iowa.

THE WOMAN ASKS THE DOCTOR. By Emil Novak, M.D. Baltimore: The Williams and Wilkins Company, 1935. 189 p.

Dr. Novak, who has been on the staff of the Department of Gynecology of the Johns Hopkins Medical School for many years and who is a recognized authority on clinical endocrinology of the female, has paused from his numerous scientific writings to give to the layman a delightfully readable book on those things that pertain specifically to womanhood. The author says: "There are countless women who, quite understandably, are eager to know something of the significance of the remarkable cyclical phenomena which characterize their sex," and he continues with the statement: "I have deliberately chosen to discuss only those problems in which my experience teaches me that all women are interested, and those in which I think they most need instruction."

The reader will not find in this book another rehash of the usual material in the "sex" books that have appeared with great frequency in recent years. In fact, the only appearance of any discussion of sex is in the last chapter, which is naïvely entitled *A Little About the Sex Life of Woman,* and begins with the statement, "This book is written by a rather old-fashioned fellow who still thinks that the sex life of every married couple is a very individual problem."

The subject matter of the book is a remarkably clear and simple exposition of the physiologic processes that are peculiar to the female sex. They are in essence those things which "the woman asks the doctor."

The content of the book may best be given by detailing some of the chapter headings: *What Is Femaleness?; The Cause and Significance of Menstruation; The Glands as Related to Female Functions; The "Change of Life" (Menopause); Some Common Disorders of Menstruation; Sterility in Women; Leucorrhea.* Dr. Novak expressly states, "It would be rather disappointing to me if this little work were interpreted as a sort of popularized textbook of gynecology," and he has "tried to talk collectively to many women as every physician and every gynecologist must often, in his consulting room, talk to one woman."

The position of the author in American gynecology places the factual matter of this book beyond question. Also, the author has succeeded in talking to the layman in his own language. Far too often physicians have a tendency to retire behind a barrage of high-sounding medical terminology which is utterly incomprehensible to the layman, and the result is hopeless confusion. Dr. Novak has not done this, but has employed simple language without loss of lucid explanation, and his style is clear and delightful.

This book decidedly fills a need that has long been felt.

University Hospitals, Iowa City, Iowa. WILLIAM F. MENGERT.

NORMATIVE PSYCHOLOGY OF RELIGION. By Henry Nelson Wieman and Regina Westcott–Wieman. New York: Crowell Publishing Company, 1935. 574 p.

Dr. Wieman is a member of the faculty of the University of Chicago, where he teaches the philosophy of religion and lectures on the theory of values, "with interest always directed primarily to the needs of religious living" (Introduction, p. viii). His wife, Regina Westcott–Wieman, is a consulting psychologist and has held the position of dean of women as well as teacher of psychology. She has "done extensive work in the areas of parent education and the social education and adjustment of young people" (publishers' note). The book is, according to Dr. Wieman, the joint effort of these two people, but certain chapters belong to one rather than the other. The combination of these two points of view, resulting from such differing experiences, has produced a challenging volume.

The authors give religion a highly inclusive definition: an individual's devotion and loyalty to what he holds to be of greatest value "not only to himself, but for all human living" (p. 29). Thus a man's religion would not include his bodily pleasures, but might include any object in the æsthetic, political, or economic field. The important question to be answered is, Of what type is this devotion? Also, how worthy is the object of the devotion? In order to answer these questions, the authors analyze the religious behavior of men and set up criteria as to the worth of the object and the quality of the devotion.

The method of the book is partly described in a statement from the introduction by Dr. Henry Wieman: "Religious living must be seen in functional connection with all the most deep and intimate interests of human personality and society." It includes, therefore, analysis of religious emotion and evaluation of religious practices. In the opinion of this reviewer, such evaluation is at points carried so far that the psychological character of the study is lost sight of. Psychology, presumably, does not judge, but attempts to understand and describe with a view to "prediction and control."

The question at once asks itself: Why review such a work for a journal concerned with mental hygiene? In the first chapter, I believe, is sufficient answer: "It is what a man believes and not what he knows which dominates his behavior. Factual knowledge has no real power over him until it becomes emotionally incorporated into his system of beliefs" (pp. 3 and 4). This first chapter, *The Psychological Problem,* is full of profound interpretations of the part religion has played and is playing in human affairs and development. The chapter ends with a statement which completes the answer to this question: "Religion is the most important way which man has

tried by which to organize the order of life" (p. 21). For if life is organized, if order can be brought out of the confusion which characterizes much living and thinking, then the battle of Mental Hygiene is more than half, if not wholly, won. "Religion is a process of organizing the self around and toward the highest values." In the opinion of the authors the psychology of religion must concern itself not only with the study of that behavior which may be considered religious, but also with the object toward which this behavior is directed. The life of the religious man is organized about some object which to him represents highest value. That religion is most worthy which is capable of bringing about the most complete organization—which carries with it loyalty to Supreme Value. And supreme value is defined as "growth of meaning in the world." This sounds at first vague and intangible, but the authors lead the reader painstakingly from step to step until this definition becomes not only clear, but practical.

An outstanding chapter in an outstanding book on child psychology (by J. J. B. Morgan) is entitled *The Development of Meaning.* It points out the importance to a child's successful relations with the world around him—his environment—of constantly growing *meaning.* The place of adults in introducing a child to the significance of acts and things is emphasized and practical suggestions are made, and all with reference to later adjustment and satisfying living. The interpretation of God, therefore, as supreme value and constant growth in meaning is illuminated by this emphasis in the psychology of childhood. The superhuman character of God is accepted, but not the supernatural, and this distinction constitutes one of the most fascinating concepts that the book offers.

Mental health is soon undermined if life comes to have less and less meaning for an individual. Mental health is quite disrupted if life's meanings are illusory or delusional. The healthy mind and a real concern with religion are soon found to be closely related if the definitions of religion and of God that are here set forth are accepted. Long ago the "expulsive power of a new affection" was recognized as a way of overcoming destructive attitudes or behavior. It is on this basis that some of the downtown missions carry on a successful warfare against drink and drugs—for that some of it is successful only those who refuse to look into it can deny.

The *excellent* religion is that which directs devotion and loyalty toward supreme value—the most truly worthful. And an "excellent religion" can fully organize life so that confusion and vagueness and conflict are left behind. The reasons why "growth of meaning" is "supremely worthful" are as follows:

> "It creates and sustains human personality.
>
> "It carries human personality to whatsoever highest fulfilments are possible to it.
>
> "It has more worth than personality; hence human personality finds its highest destiny in giving itself to this growth, to be mastered, used, and transformed by it into the fabric of emerging values.
>
> "The greatest values can be poured into human life only as we yield ourselves to the domination and control of this growth. When we try to dominate and use it, we lose these values." (p. 52.)

There are meanings outside of and beyond ourselves to which we reach out, and when these are in accordance with the laws of nature, life is strengthened and challenged to go on to farther and fuller meanings. There is nothing of the opiate in this conception of religion, no running for shelter to a higher power, no turning the back on the demands of this life, but a full acceptance of responsibilities and a recognition of the possibilities of richer experiences ahead if new meanings as they come are grasped and used.

The portions of the book of greatest interest to mental-hygienists are those concerned with the personal problems which may interfere with full expression of loyalty to the highest value one knows. Part IV is called *Problems in Religious Living*. It deals with those psychological concepts and social changes which are profoundly affecting the religious attitudes of people to-day and suggests "how human behavior can be controlled and directed toward those ends that best serve to enrich and enlarge personal and group living" (p. 412). The chapters *Psychotherapy and Religion* and *Counseling Procedures* are full of practical suggestions and searching analysis.

Outstanding chapters, however, in this connection, although not so immediately applicable, are Chapter XVI, *Developing A Personal Philosophy of Religion,* and Chapter XVII, *Progressive Integration of Personality.*

Human personality cannot be satisfactorily understood or interpreted through the sole use of mathematical formulæ or the more or less rigid definitions of abnormal or psychoanalytical psychology. All these give much needed help and personal counseling, and therapy would be much handicapped by their disappearance. But there are reaches of man's mind and spirit that can be glimpsed only by insights made keen through understanding of this need for "religion." Ideas and ideals are the elements in these reaches. "The structure of the person whose living is organized and reorganized continuously by ideas is always in the process of growth and hence is constantly exhibiting new forms and meanings" (p. 300).

"Ideals are ideas which the individual wills to carry through to fulfilment. The building up of this body of ideals is what constitutes

that aspect of development called *spiritual.* The spiritual aspect is that which is not yet realized in the self, but which the individual wills to realize. The spiritual consists of desires to become" (p. 308).

Empty is the life indeed when no such "desires to become" have dynamic power. And emptiness is above all things mentally unhealthy. The authors urge experimental living, which "involves not only courageous, sensitive, and industrious exploring and devotion, but also keen, honest, and accurate evaluation" (p. 309). Then will come about that integration which is dependent on use of ideals in the search for supreme value and on a "progression of loyalties . . . so that growth pushes out continuously into farther reaches and toward merging possibilities" (p. 331).

Personal counseling and therapy can have no higher aim than to guide the suffering or questing or confused individual into zeal for experimental living, spiritual adventure, and unlimited growth.

ELEANOR HOPE JOHNSON.

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MUSIC IN INSTITUTIONS. By Willem van de Wall. New York: Russell Sage Foundation, 1936. 457 p.

Now and then a book issues from the press which rises high above the surface of what has hitherto appeared in the particular field of human endeavor with which it deals. Such a book is that entitled ***Music In Institutions.*** Out of an experience in the general musical field as guide, director, and instructor, out of his researches and his first-hand acquaintance with adapting means and methods for the use of music in many institutions, Dr. van de Wall has, with constructive purpose, made a body of knowledge available for all interested individuals. For the administrator, the book is an exponent of the place and function of music in his institution; for his musically specialized assistant it is an authoritative guide; for many situations it contains suggestions ranging from the elementary to the technical which recommend it as a manual for constant use.

The material, which is presented in 450 pages, is divided into five parts, each containing subtitled chapters, so arranged as to give a ready analytical grasp of the whole subject. There are a goodly number of illustrations which convey more than words. There is an extensive, selected bibliography.

Part I opens with a statement concerning music as a dynamic social and educational factor, with a place as clearly defined in institutional as in cultural life. Discussion of the psychological influence of music

moves on through considerations of the sensory, perceptual, and associational responses and penetrates into the relations of music to affectivity. These are treated with the scientific discernment of established observation and the experienced judgment of the author.

An important part of the subject matter is the place and function of music in welfare institutions, whether large or small. In any case music should be under planned control, but with a flexibility of program which does not quench spontaneity. For the large institution music belongs in a department division, sponsored by the superintendent, with a musical director at its head. Such a department, with all its musical implications, should be an integral part of the institution, functioning as an organic member of the whole.

Certain chapters deal with the qualifications of the director of the music department, not only as regards musical attainments and knowledge, but in the matters of personality and cultural background, for this official, in approach to, contact with, and guidance of the individual or the group or the whole institution, has in the last analysis everything to do with the success of the department.

Music in itself is not the end and aim. The goal to which attention is called throughout the book is that of bringing about the social education and integration of the personality of the inmate against the time when he shall leave the institution. In long-continued-treatment cases the aim is to ameliorate attitudes.

Music as a therapy has passed beyond the experimental stage; it is an added form of occupational therapy. It has the property of stimulating trends, of influencing conduct toward socialized habits and thinking. The most important part of this therapy in practice is that the inmates, individually and in groups, and perhaps the institution en masse, are themselves the producers and the performers from the simple to the elaborate — in rhythmics, instrumental music of all varieties, vocal, group, and community singing, drama, pageantry, and classical, mythical, and historical presentations.

The use of music on the plans described has been introduced in numerous welfare institutions, but in far too few, for it offers a valuable form of therapy. We believe that a reading of this book by institutional workers, musicians, psychologists, and psychiatrists must convince them of this. Dr. van de Wall and the Russell Sage Foundation have performed a great service in showing the *how* and the *why* of introducing and carrying out this form of therapy.

ARTHUR H. HARRINGTON.

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PRINCIPLES AND PRACTICE OF RECREATIONAL THERAPY. By John Eisele Davis, in collaboration with William Rush Dunton, Jr., M.D. New York: A. S. Barnes and Company, 1936. 206 p.

Recreation is recognized as a most essential part of the balanced program of work, rest, and play. If this means so much in the life of the normal individual, how much more necessary it is to the mentally ill who, because of their illness, have fewer outlets for pleasurable and constructive activities. A diversified program of recreational activities is accepted as indispensable to the maintenance of good morale and as a most important factor in rehabilitation.

As an adjuvant in the treatment of the mentally ill, it was dreamed of by those who pioneered in the advance of psychiatric practice more than a hundred years ago. If prior to the last decade or two its development was less rapid than that of occupational therapy, this was because hospital personnel did not then include those with the interests and qualifications of the authors of this book.

Defining recreational therapy as "any free, voluntary, and expressive activity, motor, sensory, or mental, vitalized by the expansive play spirit, sustained by deep-rooted pleasurable attributes, and evoked by wholesome, emotional release, prescribed by medical authority as an adjuvant in treatment," the writers, drawing upon their daily experience in directing recreational-therapy programs for psychotic and neurotic patients, proceed to present theory and practice in a most informative manner. This first treatise on the subject is unique in that it is the result of the collaboration of a physician who has done much to develop resocializing physical therapy and a physical director whose experience with an unusually difficult type of patient is richly reflected in its pages.

In the first chapter types and disease entities are presented in a concise and informative manner. In Chapter 2, *Education and Reëducation*, the writers point out that, viewed educationally, all types of the mentally ill are capable of some degree of physical and social readjustment, and proceed to indicate teaching methods and adjustments. They state: "One of the weaknesses of many systems of therapy is that these cater to the rediscovery and reëstablishment of many habit patterns desirable in themselves, but because of their basic reflex character have little effect upon the modifiable thought structure of the mind." These conditioned impulses may be used as a valuable tool to effect initial participation in some desirable therapeutic exercise.

Space permits mention of only a few of all the valuable data contained in this chapter, such as general hints for getting patients to

do things of a constructive character, resocializing tendencies, a chart graphically presenting the theoretical steps of resocialization, and the use of active water therapy (swimming) in the treatment of regressed mental conditions.

Chapter 3 presents a number of cases under the classification of physical therapy for suicidal patients and for acute service.

A chapter is devoted to the classification of activities and another to measurements of physical condition and capacity, motor skill, and psychological and social-adjustment tests.

A very valuable chapter considers the use of formal and informal exercise. In the final chapter, *Aims and Objectives for Alert Types,* mildly regressed and regressed patients are clearly presented, classified as follows: "For physical fitness, for mental health and efficiency, for social moral character, for emotional expression and control, for appreciation." The detailed summer and winter schedules for both active and passive types will be found most helpful by the physician and therapist. The rest of this chapter presents an outline for a training course for nurses, attendants, and others, to be given by the psychiatrist and the physical director. A glossary completes this valuable book.

In the opinion of the reviewer the book fills a long felt need and will be of value to the psychiatrist, the physical director, the director of occupational therapy, and to all who are interested in the rehabilitation of the mentally ill.

Louis J. Haas.

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Parents' Questions. By The Child Study Association of America. New York: Harper and Brothers, 1936. 312 p.

As far as parents' literature is concerned, this most recently published book of The Child Study Association of America has just about taken the exaggeration out of the joke, "I don't need a book; I have one."

Most psychiatrists and social workers, many teachers, clergymen, and doctors, and a few parents agree that in human relationships, technical knowledge is less important than attitudes. Knowledge is valuable primarily as it is assimilated into an attitude. No thoughtful reader of *Parents' Questions* could doubt the vast fund of knowledge about parents, children, the family, the school, the community, the pressures and releases, conflicts and unities that enter into all these factors, and the bearing of one upon the other. But the element for which this book is remarkable is that consistently throughout,

from the first sentence to the last, an attitude is vividly portrayed: an attitude of seeking for understanding, of tolerance and consideration even prior to understanding; an attitude that encourages the parent to seek within herself for the possible causes of a child's behavior, and the subconscious motivation for her own feeling toward it. It is an attitude ripened through nearly fifty years of practical, earnest work with hundreds of parents and children, and conveyed throughout the book in practical terms.

The book reveals the realistic experience of contacts with mothers in their everyday, natural environments, talking, or writing to a friend, of the questions great and small which they have regarding their children, their husbands, themselves.

Invariably the answer comes with the sincere recognition that no question can reveal all the factors involved and that no answer can carry a complete solution. The answer frequently conveys certain factual information gleaned from authorities on the matter under discussion. Sometimes it contains questions suggestive of various approaches to the problem. But whatever form the answers take, the basically understanding, tolerant attitude pervades them all. Sometimes the significance of attitudes is specifically mentioned — always it is present.

For facility of organization and reference, the volume is divided into eleven chapters with headings such as *The Question and the Questioner, Discipline and Authority, Heredity and Training, The Child's Emotions, Sex in Childhood, Parents as People.* At the close of each chapter there is a case story illustrating longer-time contact than is possible through written questions and answers. In these records the problem is outlined, the counselor's experience with the parent is briefly summarized, and the general outcome is indicated, with some interpretative comment by the counselor. This part of the book comprises a less unique contribution then does the question-and-answer content. Mental-hygiene literature is full of brief or lengthy case histories. One might wonder a bit about including them in *Parents' Questions.* For the reader trained in psychiatric concepts, this case material offers nothing particularly new. There might be some doubt as to whether the interpretations would be very meaningful to the unpsychiatric reader. But this is a minor doubt. The stories are interestingly told and they carry the same attitude of thoughtful seeking.

Parents' Questions is interesting reading for psychiatrists and social workers because of its demonstration of matured skill in the art of being truly helpful to people by the acceptedly difficult question-answer method.

Physicians, teachers, and others who deal intimately with problems of human relationships can gain much from the mellow philosophy and the wealth of material revealing what thoughts, fears, questions, satisfactions, and experiences go on beneath the casual-appearing surface of the average family life.

Parents themselves can benefit through most of the foregoing values, and in addition can be relieved of some of their frequently uncomfortable sense of difference by learning of the hundreds of other parents who have the same problems.

Many more technical books give more specific information about various aspects of parent and child development, but a parent who acquires the attitude that enriches *Parents' Questions* need not worry much about technical knowledge. She will just live along and be a pretty good parent.

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READINGS IN MENTAL HYGIENE. By Ernest R. Groves and Phyllis Blanchard. New York: Henry Holt and Company, 1936. 596 p.

The authors offer this volume as a companion to their previous book, *Introduction to Mental Hygiene.* They saw the need of a source book that would bring together in a single volume selections from the widely scattered literature on mental hygiene, together with the various aspects of the subject and the practical application of its principles. Much of this material would be available only to those who had access to a highly specialized type of library.

A second function of the book is that of making available to a relatively large group, such as teachers, social workers, and other professional workers, a large number of the more acceptable and pertinent articles on the wide range of subjects touched upon by mental hygiene.

The articles selected are grouped under sixteen headings: (1) *The Origin and Development of Mental Hygiene;* (2) *Psychiatric and Psychological Background;* (3) *The Problem of Mental Disease;* (4) *Delinquency as a Mental Health Problem;* (5) *Mental Hygiene in Childhood;* (6) *Mental Hygiene in Adolescence;* (7) *Mental Hygiene in Marriage;* (8) *Mental Hygiene in School;* (9) *Mental Hygiene in the College and the University;* (10) *Mental Hygiene in Business and Industry;* (11) *Recreation and Mental Adjustment;* (12) *Mental Hygiene and Religion;* (13) *Mental Hygiene Aspects of Literature;* (14) *Social Work in Mental Hygiene;* (15) *Mental Hygiene and Public Opinion;* (16) *Larger Aspects of Mental Hygiene.*

It is evident from a study of the book that the selection of the "readings" has been made with the utmost care and a most careful consideration of the contributions in the various fields. It very definitely presents a balanced diet of reading in mental hygiene for those new in the field and for those who have not time to devote themselves to a careful study of the literature.

While, as would be expected, a large number of the articles are taken from MENTAL HYGIENE, many other books and journals and separate articles are referred to. On the basis of its merits, the book should find a large field of usefulness.

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AUTISTIC GESTURES; AN EXPERIMENTAL STUDY IN SYMBOLIC MOVEMENT. By Maurice H. Krout. Princeton, New Jersey: Psychological Review Company, 1935. 126 p.

Autistic gestures include such unconscious and apparently meaningless motor movements as adjusting glasses, biting lips, blushing, breaking matches, and so forth. A list of 340 such gestures is given in the appendix. Essentially, the author's thesis is that these movements are meaningful and significant for the study of personality. While this general thesis is doubtless sound, the methods employed by the author leave much to be desired.

The first two chapters emphasize the fact that while others have used word-association tests and time-sampling observational methods, the author is the first to use them together. This is a naïve emphasis.

Chapter 3 presents preliminary and most inadequate experiments in excessive detail.

Chapter 4 purports to show that the author's observers are reliable in reporting the number of motor responses to stimulus words. The data merely show, however, that some subjects habitually make a large number of random movements and that other subjects are relatively immobile. There is not an iota of evidence to show that the nature of the stimulus words has anything to do with these differences.

Chapter 5 attempts to show that the motor responses to stimulus words given under slightly different conditions tend to be consistent. With the exception of the data from the hypnotic trance, the evidence for consistent motor response is most inadequate. While the similarity of the motor responses to verbal stimuli in the waking state and in the hypnotic trance is striking, this similarity follows from the fact that the subject was asked to act during hypnosis exactly as he had acted during the waking state.

In Chapter 6 there is some evidence from a series of experiments that autistic gestures may have their origin in emotional tensions. That is, the motor responses to crucial and emotional stimulus words such as "gland," "woman," and "body" are significantly different from responses to non-crucial and indifferent words. The evidence, however, is not consistent and there is a complete absence of evidence to show specific ties between stimulus words and motor responses, which the theory of the previous chapter would seem to require.

Chapter 7 presents additional evidence on the conflict and emotional origin of autistic gestures based on a more intensive study of two cases in relation to a detailed study of their past experiences and personality. This is, of course, the type of material in which it is easy to find what the author wants to find.

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SOCIAL DETERMINANTS IN JUVENILE DELINQUENCY. By T. Earl Sullenger. New York: John Wiley and Sons, 1936. 412 p.

The author of this book presents a general review of the literature, together with some researches which he has made himself concerning one phase of the causation of juvenile delinquency — the social. His personal researches in this field were made in Omaha, Nebraska, and Columbia, Missouri. Although these cities probably may be considered typical of those in the Middle West, the distribution of population noted in the author's figures is certainly startlingly different from that seen along the Eastern seaboard.

As is to be expected from the fact that the author is professor of sociology in the University of Omaha, and that the title is limited as it is, we find the stress laid upon the social factors to the almost entire exclusion of the strictly psychiatric features of the problem. On page 7, for example, the author says, "We regard the so-called delinquent child as a misdirected normal human being." Further on, however (p. 97), in treating of the school, he points out the value of a psychiatric clinic attached to the school for the purpose of recognizing the first symptoms of neurosis and antisocial tendencies. He recommends, too, an extension of the program of vocational guidance, training, and placement, and the development of wholesome leisure interests and activities. He wisely lays great emphasis upon the school as a factor in the prevention of juvenile delinquency and concludes his chapter on the school with the statement that "the school that solves the problem of good citizenship and socialized education solves the major portion of the problem of delinquency."

In dealing with the family, the author points out that from his statistics it would appear that the broken home has a considerably more marked adverse effect upon girls than upon boys (p. 21), and that in a considerable number of instances the incompetence of the parents in dealing with this problem would appear to be almost as serious as the fact that the home is broken (p. 23).

In dealing with the neighborhood, it is suggested that the lack of adequate play facilities for adolescent Negro youths is probably an important factor in the disproportionately high delinquency rate for Negroes. In Chicago and Indianapolis, for example, the delinquency rate for Negroes is almost three times their proportion of the population, thus illustrating the need for further attention to this group. In dealing with population the author inclines to the view that although juvenile delinquency is frequently associated with density of population, it is not necessarily determined by it (p. 183).

Considerable attention is given by the author to the question of the prophylaxis of delinquency; and such agencies as the policewoman, the juvenile court, juvenile probation, and the child-guidance clinic are given a due share of consideration as practical and valuable methods of reducing the incidence. That the author claims no panacea and has a conservative attitude toward the problem is indicated by his final statement: "We have found no unit causes of crime and recommend no unit cures. It is recognized that every individual leads a social existence and that both the treatment and the prevention of crime must consider not alone the individual transgressor, but also the entire primary social group of which he is a functioning unit. Further, it is recognized that it is necessary to carry on extensive programs coping with the adverse social and economic conditions whose influences are constant factors in criminal careers."

Extensive bibliographies are appended to each chapter and there is a general bibliography at the end of the volume, together with seven appendices giving further details on special topics. The volume is of value as an introduction to the study of an important phase of juvenile delinquency.

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NOTES AND COMMENTS

Compiled by
PAUL O. KOMORA
The National Committee for Mental Hygiene

TWENTY-SEVENTH ANNUAL MEETING OF THE NATIONAL COMMITTEE FOR MENTAL HYGIENE

The Twenty-seventh Annual Meeting of The National Committee for Mental Hygiene was held on November 12 at the Hotel Roosevelt in New York City. The occasion marked the renewal of the series of luncheons held by the National Committee in the past, which, before the depression, brought together annually large groups of interested followers of its work. Over eight hundred members and guests were present, the largest attendance ever attracted to these luncheons. The speakers were Dr. C.-E. A. Winslow, Professor of Public Health at the Yale School of Medicine; Dr. Bernard Sachs, Chief of the Division of Child Neurology of the New York Neurological Institute and Vice-President of the National Committee; Dr. Nolan D. C. Lewis, Director of the New York State Psychiatric Institute and Hospital; Dr. Marion E. Kenworthy, Director of the Mental Hygiene Department of the New York School of Social Work; and Dr. Clarence M. Hincks, General Director of the National Committee. Dr. Arthur H. Ruggles, President of the National Committee, presided.

Dr. Kenworthy presented a tribute to the late Dr. Frankwood E. Williams, former Medical Director of the National Committee, which is published elsewhere in this journal.

The twentieth century is destined to take its place in history as the great period of achievement in the field of mental health, Dr. Winslow told his audience. Our health ideals to-day, he said, are much wider in their scope than they have ever been before; health promotion means more than the control of obviously serious disease — more even then disease prevention. "Fullness of living is our objective. From this standpoint we see mental hygiene as concerned not alone with hospitals for the insane and the feebleminded, with behavior clinics and child guidance. We visualize it as a permeating influence in our entire educational and social system, subtly changing every man's attitude toward himself and his fellow man." The task of science, Dr. Winslow continued, is to substitute an objective understanding of causal relationships and a purposeful control

of those relationships for the "helpless awe with which primitive man regards the mysterious universe around him."

"In the nineteenth century the laws of physics and chemistry were so far unveiled as to give to the human race a basic understanding and a far-reaching control of the material world. Biological science has advanced far enough to reduce by nearly one-half the burden of disease and death. The next major problem is the extension of understanding and control in the more complex and the more obscure field of operation of the human mind and the human emotions. It is here that the great problems of to-day are found. It is here that the future of civilization must be determined. The twentieth century will, I believe, take its place in history as the great period of advancement in this area of knowledge. . . . Our only hope of success is in mental hygiene. We have in the comprehension of human motivation the key which can unlock the door of the future, the sword which can cut the knots of emotional complexes which tie us to the past."

Dr. Sachs spoke on the topic, "Research in Relation to Problems of Early Life." He stressed the importance of studying carefully and in an unbiased fashion the earliest manifestations of personality changes and oddities of behavior, especially in children of families in which manic-depressive psychoses and other forms of mental disease recur. Psychiatrists, teachers, and others, he said, can contribute to the advancement of our general knowledge with regard to these disorders of early life. "Much may be done in the way of sober determination of facts, without attaching undue importance to theories which may have a present vogue, or without reiterating beliefs which are to prove or disprove certain doctrines."

In this connection, Dr. Sachs called attention to the "child-neurology research" project of which he is director and the organization of which has been entrusted to him by the Friedsam Foundation. The council that is advising the project, he said, will welcome original research along psychologic or psychiatric lines that will definitely advance knowledge in this field.

Dr. Lewis discussed the program of research in dementia praecox initiated and financed by the Scottish Rite Masons, Northern Jurisdiction, under the direction of The National Committee for Mental Hygiene. He saw in this project the beginnings of what may eventually become the most thorough, concerted attempt ever made to solve "what is perhaps the largest problem in our present-day society." In studying such a vast problem, he said, it was necessary to have not only working ideas, but ideals also, and he expressed the belief that the present organization is fully endowed with these two

sets of necessary factors. He described the philosophy of the program, in its approach and plan, its rationale and objectives, as follows:

> "1. We wish to move forward by a process of evolution and not by revolution. In this way we can utilize much that has gone before. In fact, our thoughts and plans contain much that is old. Revolution discards all that is old; evolution uses it.
>
> "2. We wish to build a research organization which will stimulate and encourage those in the field to put forth an additional effort. Many places and people capable of working in this field are now suffering from what I like to call 'accidia.' Accidia is a state of mind, an occupational disorder of the contemplative life, a state of inertia, a bleak lack of interest, and at least a temporary suspension of faith. Some of these can be revived, and many are being revitalized.
>
> "3. We aim to simulate, train, and otherwise aid the younger, capable men who are attempting or contemplating leading a life of research. We must point out to them the opportunities in our specialty and in what way investigations in the fundamental sciences may contribute to our final solutions.
>
> "4. The research-organization headquarters must become a center of information regarding these problems. It must become the center of bibliographic reference; it must know the whereabouts of literally hundreds of research workers—what they are doing, their special interests, what new disciplines are being evolved, and how they may contribute to the activities. This type of activity is already under way.
>
> "5. Regardless of our personal beliefs as to the fundamental causes of our mental disorders, we must cultivate the attitude of tolerance for a wide variety of approaches and studies.
>
> "6. There are 'ideal research men.' We want to know where they are and what they may be able to do. As 'contact man' for this organized research, I do not size up a research worker according to the poundal weight of his books or according to the number of his written articles, but I look for the tools with which he works, and these tools are not constructed of brass and steel. They are the aspects of a trained intelligence — the sooner we learn that there is no mechanical substitute for a keen and trained intelligence, the better — and there are just three of these tools that are worth serious attention: namely, the faculty of constructive imagination and vision; the art or faculty of logical tentative reasoning; and the faculty of observation and not just seeing. We aim to keep track of the men who have and can use these three tools. They are the originators of our future methods. We have reserved no place in our program for the exponents of 'imaginative literalness,' 'complacent dogmatism,' and 'parrotlike pedantry'."

Dr. Hincks summarized the activities of the National Committee during the past year and indicated present and future trends in its work. While the pattern of work has not altered through the twenty-seven years of the Committee's history, he pointed out, the foci of its interests have been shifted to meet the changing demands of an ever-expanding field. For example, it is keenly interested in research, in the training of personnel, in clinics and community programs for

mental health, in safeguarding the mental health of children, and in public education. The newer developments, Dr. Hincks said, are materially affecting outlook and practices in medicine and nursing, education, social work, and other fields. In looking to the future, "our committee can with profit maintain its interest in the problems presented by those who are mentally ill, subnormal, or maladjusted, and at the same time extend its activities in the direction of prevention and life enrichment."

Indicating how the special contribution of positive mental hygiene to these various fields has been made possible, in large measure, by psychiatric experience with the maladjusted, Dr. Hincks cited the work with mental defectives. "It was found necessary," he said, to train mentally deficient children in line with their intellectual capacities — to have training related to the acquisition of skills that could be put to practical account in the lives of pupils. Now these principles are found to hold true for all children. Progressive educators advocate them. And thus we find that the challenge presented by the feebleminded has led to a distinct advance in education generally." The further we go in gaining an understanding of the pathological, he added, the better equipped we will be to assist the average individual. "Indeed, I look forward to the day when the mental hospital, in investigating pronounced disturbances of the emotional and mental life, will furnish us with valuable leads for more effective training of college and university students — effective training for life."

Mental Hygiene and Health Departments

Apparently assigning a permanent place on its program to mental hygiene, the American Public Health Association again devoted a special session to the subject at its annual convention, held this year in New Orleans, October 20–23. Papers were presented by Dr. W. T. B. Mitchell, Director of the Mental Hygiene Institute of Montreal and Assistant Professor of Mental Hygiene at McGill University; Dr. B. T. McGhie, Deputy Minister of the Ontario Department of Health; Dr. Eric Kent Clarke, Associate Professor of Medicine, University of Rochester, School of Medicine; Dr. Charles E. Shepard, of the American Youth Commission of the American Council on Education, Washington, D. C.; Dr. Ruth E. Fairbank, of the School of Hygiene and Public Health, Johns Hopkins University, Baltimore; and Dr. B. Liber, of New York City.

Speaking on the integration of mental hygiene in the field of public health, Dr. Mitchell declared that any program of public health and preventive medicine, to be adequate, must approach its problem on

the assumption that the physical and mental aspects of health represent "one single complex state of adjustment," and that any program of therapy or prevention which does not adopt this approach "lacks effectiveness and balance in much the same way as a boxer with one hand out of action." He said further that the public-health group is now in a vulnerable, as well as strategic position, in that "they cannot afford to overlook an aspect of health effort as inclusive as that to which they have been giving the major part of their attention, while they are in a position, at the same time, to make a contribution which promises more in the way of returns over the next decade than perhaps any other development in the social or medical fields."

Exactly the same principles and practices are applicable to mental as to physical hygiene, Dr. Mitchell asserted, in so far as they seek to provide the positive factors that favor growth, to simplify the environment by the removal of certain health hazards, and to build up resistance in the individual by establishing specific immunities to certain other hazards. Hence both depend on general and specific educational measures which aim to acquaint the public with the elements and factors that make for healthy growth and with the means to be taken to avoid sickness.

Apart from general health measures for the elimination of organic, toxic, and other physical factors accompanied by disturbed mental functioning, there is only one major gateway to mental health, Dr. Mitchell said, and that is through mental growth. "Adequate mental growth," he explained, "implies a progressive redistribution of interest-energy from self to outside interests. In the course of this process, there must take place a progressive replacement of infantile self-values and infantile sources of satisfaction by adult social values and adult satisfactions." That is, this process involves a continuous relinquishing of values which are normal for one phase of development in favor of values which we recognize as normal for a later period, and it "goes forward satisfactorily, given reasonably favorable conditions, just as physical growth proceeds under comparably favorable conditions."

Since this redistribution of interest is the best single criterion we have for healthy mental growth, Dr. Mitchell said, the emphasis of the public-health program must be on the growth process, insuring so far as is possible conditions under which growth may proceed in a healthy fashion. Accordingly, the integration of a mental-health approach requires that the personnel of health departments shall be familiar with: (1) the way in which mental growth proceeds; (2) the factors that favor or interfere with healthy mental growth; (3) behavior responses at all points in the developmental period which suggest sig-

nificant deviations from mental health; (4) the place of inheritance in relation to mental disorder, since much of the public's fear and misunderstanding of mental disease is based on misconceptions in this connection; and (5) the laws of learning.

Dr. Fairbank described the mental-hygiene study in progress in the Eastern Health District of Baltimore, which is aiming to devise and put into experimental operation, as part of the existing health service of that community, such administrative procedures as would seem to offer hope of an effective management and prevention of mental disorders. It was organized by Johns Hopkins University, in 1934, as a joint project of the Department of Psychiatry of the Medical School and the School of Hygiene and Public Health, under a grant from the Rockefeller Foundation. Adopting the "epidemiological" approach, the study has undertaken to determine the incidence of mental disease, defect, and dysfunction for the year 1933, and to discover in as great detail as possible the economic, social, racial, and personal factors that underlie these conditions.

Statistical analysis of the information already secured, showing the prevalence of behavior problems in children, as well as of adult cases of mental illness, which do not reach psychiatric help, has led to the inauguration of the following administrative measures as a first attack on the preventive phase of the mental-health problem: (1) the organization of an experimental consultation service for the education in early child training of mothers who bring their babies regularly to one of the existing child-hygiene clinics; and (2) a psychiatric consultation service offered to local physicians for such cases as are too ill or too indifferent to attend a clinic. The interest shown thus far in these two types of experiments has been encouraging, Dr. Fairbank said, and the investigations so far made indicate strongly that "integration of a mental-hygiene study group with the regular public-health department offers an ideal situation for carrying out a program which embraces the mental, emotional, and physical health of the community."

That community responsibility for mental health is rapidly becoming an important phase of public-health administration was indicated by Dr. Clarke, who presented his experience as Director of the Division of Psychiatry of the Rochester Bureau of Health. A public-health setting for mental-hygiene work is advantageous, he said, because it is not limited to any one age group or any one type of problem. Child-guidance work, for example, can be developed with pre-school children through the nutrition and well-baby clinics and the prenatal-care centers, and through the services of public-health nurses, and the school physician and school nurse can carry on this work in the educa-

tional system. In Rochester, Dr. Clarke said, diagnostic and remedial work with adults is organized as a municipal-hospital service, through a consultative court service, and under a coöperative plan with the Bureau of Public Welfare.

Discussing the practicability of mental-hygiene programs in schools and colleges, Dr. Shepard reported a study which he made of a wide sampling of programs now in operation, in terms of definition of programs, placement in school and college organizations, practical limitations, and the results to be anticipated. This study, he said, revealed a marked trend toward the inclusion of mental-health services as part of the broader programs concerned with community health and welfare.

Mental-Hygienists Address Nurses' Convention

Mental health was a major topic of discussion at the annual joint convention of the New York State Nurses' Association and its two affiliated groups, the New York State Organization for Public Health Nursing and the New York State League of Nursing Education, held on October 12–16 at the Hotel Pennsylvania in New York City. Miss Helen Cabot Latham, Director of the Nursery School, Bellevue Hospital; Dr. Ira S. Wile, psychiatrist and associate in pediatrics, Mt. Sinai Hospital; and Dr. Jay B. Nash, Professor of Education, New York University, spoke, respectively, on the mental health of the nursery-school child, the adolescent, and the adult. Mental health in relation to social hygiene was discussed by Professor C.-E. A. Winslow of Yale University, and Miss Effie J. Taylor, Dean and Professor of Psychiatric Nursing, the Yale School of Nursing. More than a thousand nurses attended the various sessions.

Professor Nash said that the problem of mental health is becoming increasingly acute in the modern world of confused ideals and harsh realities, and to meet it a greater amount of work of a creative, stimulative nature is needed to keep the average person mentally healthy. He added that it takes a "highly intellectual" individual to enjoy leisure, and "most of us had better count on working." It is a false assumption that all man wants is leisure, let-down, rest, sleep, freedom from work. "What man really wants is creative challenge with sufficient skills to bring him within the reach of success, so that he may have the expanding joy of achievement. Unless leisure is accompanied by drive, it lays the basis for disintegration, and the vast majority of people who have earned leisure are finding that it is becoming their Frankenstein monster." Few people overwork, he said, and few realize the joy and happiness of conquest. "Joy, happiness, and interest lay the basis for normality, and the basis of mental health

for the average adult is more work, provided the work is not mere drudgery."

Dr. Wile estimated that there were at least 1,000,000 "problem" children in the schools. The adolescent youth, he said, is one of the most important problems confronting society, for he lives in a confused world in which "it is no easy task to organize ideas of honor and justice in terms of present-day news items." He said that society "has a tremendous responsibility for the mental hygiene of our adolescent population," and that "we have great reason to demand a sound program, involving conscious effort and planning along lines of education, vocational training, recreation, and social thinking in the interest of conserving mental health. There is more need than ever for a social appreciation of the distinction between the mental-health influences that arise from the various concepts of temporal worth and spiritual growth, of economic dominance and social coöperation."

Ninth Annual Graduate Fortnight

Increasing awareness of the importance of certain industrial conditions as factors in mental health is evident from the reports of discussions which took place during the Ninth Annual "Graduate Fortnight" held by the New York Academy of Medicine from October 19 to 31. The symposium this year was devoted to the theme, "Trauma, Occupational Diseases, and Hazards."

In an illuminating paper on fatigue and noise in industry, Dr. Foster Kennedy estimated that from 60 to 80 per cent of the population to-day have ear trouble caused by mechanical noise, and he quoted an authority on ear conditions to the effect that some auditory organs are completely destroyed by prolonged exposure to loud noises. The failure to function because of noise, he added, accounts for some of the fatigue we feel at the end of the day.

Describing the psychological and emotional effects of noise, Dr. Kennedy mentioned irritation, loss of temper, quarreling, and other behavior consequences. In attempts to overcome the effects of noise, he said, great strain is put upon the nervous system, leading to neurasthenic and psychasthenic states, and long before the emotions are disturbed, certain physical changes take place, such as heightened pulse rate and blood pressure and irregularities in heart rhythm. Moreover, these disturbances may occur without the subject being conscious of them, while any impairment of hearing, "in the very nature of the case," is insidious and at first hardly noticed. The human ear is a sensitive organ and responds to impulses of the finest kind. Its reaction to noise is vividly described in the following quota-

tion from medical reports: "Remember that every sound wave is a push and a pull, a squeeze and a suck of every tissue and structure through which it passes and upon which it impinges. The normal ear has a remarkable tolerance to intense sounds, but once the critical or safety point is passed, injury follows."

Classing noise with factory dusts and poisons and other occupational hazards, Dr. Kennedy urged that "more definite action should be taken to eliminate and control industrial noises, and all the apparatus of science that can aid in abatement should be put to use." Noting recent evidences of progress in the practical application of preventive measures as "encouraging signs of growing interest in the problem," he declared that "for the betterment of our vast labor population, noise abatement should be given its rightful place in the industrial world," along with improvements in lighting, heating, ventilation, and other working conditions.

In an interesting paper on the relation of trauma to the nervous system, Dr. Israel Strauss remarked upon the relative neglect, until recently, of the remote consequences of head blows and the striking increase in head injuries resulting from industrial and motor accidents. The lack of thorough clinical examinations of the injured by competent psychiatrists immediately after the accident, he said, has added to the difficulties inherent in the problem, despite the fact that autopsies in patients who died from other causes long after injury have revealed "a surprisingly extensive destruction of cerebral tissue with no, or very little, clinical evidence of focal disease." In this connection he deplored the emphasis on objective findings, to the exclusion of the equally important subjective symptoms in such cases, due to the "pernicious effect on our medical thinking of legal procedure and rules of evidence." The total behavior of the patient, his ability to think, his attitude toward reality, his affective responses, as well as the numerous subjective complaints, are just as important in determining diagnosis and treatment.

Denying the existence of a "characteristic traumatic neurosis," Dr. Strauss said that there is no neurotic symptom complex which is found only after trauma to the head; that the nature of the neurotic symptom formation depends to a great extent on the pre-morbid make-up of the injured; and that careful study of neuroses following trauma reveals every type of reaction encountered in non-traumatic practice. On the other hand, he said that there is no question but that litigation is an added strain and undoubtedly tends to aggravate the neurotic symptoms. "Under our legal system the neurotic is unfortunately burdened by the necessity of defending himself against those who oppose his claims. He is supposed to be a plaintiff, though he is really

a defendant. It is inconceivable that any normal human being should not react unfavorably to this well-known complex of disturbing influences popularly known as a trial."

Labeling the so-called litigation neurosis as a fiction, Dr. Strauss said it is really a form of malingering, and if simulation does not exist, "we are dealing with a true neurosis perhaps aggravated by the litigation." Neurotic symptom formation, he explained, is an unconscious response to intrapsychic maladjustment, and the stress and strain of the trial is only one of many etiological factors. "It is astounding to note the persistent prevalence of the notion that malingering is synonymous with the psychologic response to trauma," he continued. "The repeated assertion that the injured deliberately exaggerate can be made only by those who lack understanding of the intricacies of the psychic mechanism. The assumption that the average working man seeks consciously to lengthen the period of his disability to obtain money without working is not borne out by my experience. The monetary gain in illness is in most cases hardly sufficient to warrant such behavior in normal times. The rôle of the profit motive in determining the conduct of the workingman and those injured in industrial accidents has been overemphasized. Everybody seeks a state of well-being, and the forces impelling one in that direction are usually more powerful than temporary economic security." Admitting that in times of economic depression the profit motive, as the secondary gain in illness, may be significant, and may intensify the symptoms, he held that it is rarely the sole cause of their appearance. "While it may lead to prolongation of illness, it is not the primary cause of the development of the neurosis."

"Traumatic Neuroses" and Workmen's Compensation

Probably the most troublesome industrial-accident cases which physicians are called upon to diagnose and treat are injuries to the head and back. Men with such injuries cannot be classified according to schedules given in workmen's compensation laws, and this group of non-scheduled injuries includes also the neurotic workman. In many states these injured men are given a final lump sum. While there has been much speculation as to the therapeutic value of such cash awards, few accurate investigations have been made as to the effect of these settlements.

These considerations led to the decision of the Rehabilitation Division of the New York State Education Department to undertake a three-year study of lump-sum-settlement cases, the results of which have just been published under the title *Vocational Rehabilitation and Workmen's Compensation*, by Carl Norcross, Ph.D., of the depart-

ment's staff. Copies of the report are available at the price of $1.00 at The Rehabilitation Clinic, 28 East 21st Street, New York City.

The report deals with the problem of "traumatic neuroses" from the practical angle of their management under the law, and if its recommendations are followed, the department believes the handling of such accident cases in New York State will be changed considerably. It concludes, after a follow-up study of 322 workmen's compensation cases throughout the state, which were closed by a lump-sum settlement of $1,000 or more, that "there is little or no therapeutic benefit in cash settlements paid to injured workmen who have traumatic neuroses."

This is contrary to the opinion generally accepted in medical and workmen's compensation circles that a cash award helps to cure a neurosis. "A careful investigation made a year or more after the settlements has convinced us that the value of a cash award is vastly overrated," the report states. "It is the settlement of the case, the actual ending of the litigation, which is of value. Whether the final compensation award is paid in one lump or extended through a number of installments, makes little difference to the claimant's condition."

Both because there was found to be a wastage of compensation funds on the part of the beneficiaries, and because there appeared to be no therapy in the settlements, the author recommends that lump-sum settlements be discontinued. Among further recommendations for the improved handling of cases, he urges that they be given more prompt and careful attention. The average neurotic case is held open in the workmen's compensation division for nearly three and one-half years, and much of this delay is unnecessary. He states that neurotic conditions grow as cases drag, and points out the danger of permitting claimants to read their own medical reports or to be present when physicians are testifying.

The author also suggests that it is poor policy to let neurotic claimants know that when their money is spent, they may try to reopen their cases. He believes that one of the evils of the existing system in non-schedule cases is the practice of urging upon claimants the acceptance of lump-sum settlements. After a fair offer is made, the claimant may stall indefinitely by refusing such a settlement. Thus the case is delayed and the patient's mental condition may become worse. The remedy suggested is that the referee, acting on competent medical advice, fix a fair settlement and close the case, the award being paid in bi-weekly installments. To overcome any prejudice the claimant may have toward the insurance company, it is further suggested that the money be paid to a state-administered

trust fund, such as already exists in New York. The carrier could then close the case on its books, and the claimant could be told that it is definitely closed, but that he will get all his money, regardless of his state of health. The patient would thus not "have to remain sick" to get his award.

Five Psychiatric Problems

Revision or amendment of the laws dealing with five common psychiatric conditions was recommended by Dr. Karl M. Bowman, Director of the Department of Psychiatry of New York City's hospital system, in an address before the Society of Medical Jurisprudence at the New York Academy of Medicine on October 12. Dr. Bowman called for new legal attitudes toward epilepsy, alcoholism, feeblemindedness, psychopathic personalities, and cases of mild mental disease. He asked for the construction of state institutions for chronic drunkards and recommended long-term commitments for psychopathic alcoholics; he appealed for the permanent segregation of persons subject to recurrent epileptic furor; and he urged that something be done to curb the spread of feeblemindedness, which, he said, was becoming an increasingly serious social problem.

Present methods of handling alcoholism and other medico-legal problems are unsatisfactory and inadequate. "We are running 1,000 cases of alcoholism a month at Bellevue," he added. "But fines of $50.00 or thirty-day jail sentences will not cure those inebriates."

The drunkard who is seized by the desire to attack and even kill other individuals should be segregated in special institutions for long terms, and hastily recommitted if, after release, he goes back to drinking intoxicants, Dr. Bowman said. Milder cases should be treated by shorter periods of institutionalization. At present only those whose families can afford to commit them to private hospitals are receiving the proper treatment for alcoholism.

There is no specific legislation, Dr. Bowman pointed out, to deal with the epileptic whose seizures are followed by furor during which violent crimes are attempted. Such a person is neither criminal nor insane, but nevertheless should be removed from society permanently. There is a marked resemblance between the furor of the epileptic and the psychopathic drunkard.

Treatment of the feebleminded is now a major social problem, Dr. Bowman continued, adding that although there was dispute as to whether the original cause of the disorder was hereditary or environmental, there was no doubt that feeblemindedness was exaggerated by residence among the underprivileged.

"Almost nothing is being done to check the spread of feeble-

mindedness," he charged. "That is how revolutions are bred. There is no danger of a violent overthrow of the government as long as a large part of our population is intelligent, sane, sound, and level-headed. But once social conditions become bad, and there develops a large group of psychopaths and feebleminded, unstable and easily swayed, revolution threatens."

Dr. Bowman proposed greater severity in the segregation of psychopathic personalities, peculiar individuals often of superior intelligence who delight in the commission of vicious crimes. He advocated that in New York a commission of highly respected psychiatrists, free from all political connections, be appointed to study psychopathic children and recommend their commitment to state institutions until twenty-one years of age.

"Many of these psychopathic children are now committed to reform schools, but when they are loosed upon society at the attainment of their majority they are most dangerous persons," he said. "If such a commission were formed, it could examine this person on his twenty-first birthday, and if the signs of a psychopathic personality persisted, recommend to a judge and jury that he be committed to an adult institution without ever being released."

Dr. Bowman concluded with two further suggestions: that the law recognize the existence of a middle state of "partial responsibility" between those utterly irresponsible, on one hand, and those mentally sound, on the other; and that a definite decision be made on the way to judge persons recuperating from mental disorders whose complete restoration to sanity is uncertain.

Children's Unit Opened at Rockland State Hospital

The new Children's Group of the Rockland State Hospital at Orangeburg, New York, was dedicated on September 24, in the presence of Governor Herbert H. Lehman; Commissioner Frederick W. Parsons, of the State Department of Mental Hygiene; Dr. Frederick Tilney, Director of the New York Neurological Institute; Dr. Douglas A. Thom, of the Massachusetts Department of Mental Diseases; Clarence H. Low, president of the hospital's board of visitors; and Dr. Russell E. Blaisdell, superintendent of the institution. Sixteen hundred guests, including physicians, social workers, hospital administrators, and child-welfare workers from New York and adjoining states, attended the ceremony.

The unit was characterized as a pioneer venture that promises significant achievement in the study and treatment of mental and behavior disorders in children and the prevention of such disorders in adult life. It is the second institution of its kind in the country,

the only other similar group in existence being the children's unit at the Allentown State Hospital in Pennsylvania. Governor Lehman described it as an outstanding event in the history of the care of the mentally afflicted in the United States. "Special hospital care of mentally sick children," he said, "is virtually a new undertaking. Aside from the care of the feebleminded and a few cottages at the Kings Park State Hospital on Long Island for children suffering from the after-effects of sleeping sickness, this state has made scant provision for our mentally ill children. Insanity is, of course, usually a disorder of adult life. There are, however, many commitments of children in their early teens, and the number is, unfortunately, increasing annually. In the past a child had to be cared for in wards with adults, but the presence of children in adult wards is undesirable from every standpoint, undesirable for the adult and frequently ruinous for the child."

Complimenting New York State on its vision, initiative, and persistence in bringing about the erection of the Children's Group, Dr. Thom saw it as one of the landmarks of progress in preventive medicine in which "the dreams and hopes of a former generation have developed into a unique research and therapeutic center which should contribute much to our knowledge." Practically every advance that has been made in medicine, psychology, and education, he said, has demonstrated convincingly that childhood is the period during which the fabric of physical, mental, and moral health is most likely to become twisted. "The plans for the development of this unit have been such that not only will those mental aberrations leading to disease be investigated and treated, but ample opportunity will be provided to study such varied types of behavior as may result in delinquency, crime, and educational and industrial inefficiency, as well as moral deviations. You have paved the way in the establishment of this children's unit that every other progressive state must follow. All those who are interested in children and in the social welfare of the coming generation are deeply indebted to the state of New York for the wisdom, idealism, and courage which are symbolized in the buildings we are dedicating to-day."

The unit consists of six cottages, accommodating 25 each, or a total of 150 child patients. These cottages are connected by corridors with a central administration building for the group, which contains an auditorium; two large classrooms—one for each sex—each of which can be subdivided into three classrooms; dining rooms; and kitchens. Special outdoor facilities are provided for recreation for the group.

Dr. Tilney traced the background of experience with childhood dis-

orders that led to the planning and creation of this project, recalling the devastating epidemic of lethargica encephalitis (sleeping sickness) that swept across the country and through other parts of the world after the great war. "Old and young alike fell before it," Dr. Tilney said, "but the most pathetic victims were the little children who survived its ravages. The disease put a blight on these poor children even before they had a chance to get started in life. They were not only handicapped by convulsions and physical ailments of various kinds, but their entire conduct underwent a serious change. Children who were lovable and tractable became just the reverse. They became a serious problem."

The children's pavilion at Kings Park represented the state's first attempt to deal with this problem. In the present unit, however, Dr. Tilney pointed out, the endeavor will be to take not the so-called organic cases, but those suffering from neuroses, fears, and behavior disorders of the functional group, and to emphasize the preventive aspects of the work. "This addition," he said, "is something more than an increase in the number of beds and in medical accommodations. It is really a growing development and recognition of the relatively modern ideal of prevention. This is certainly a wise step in selecting these patients, and in planning for their care no thought has been spared. Every possible arrangement for the cure and improvement of these little sufferers has been made, and I think we can easily forsee the great success which this organization will achieve. It will be a boon to our community, and I look to the future in the belief that this new institution for the care of mental and nervous disorders will be used so that the children will be selected and brought under treatment before their tendencies to delinquency and crime become crystallized."

After the exercises, the guests were conducted on a tour through the Children's Group and other sections of the hospital. Some of the children acted as hostesses and aided in showing the visitors through the cottages and explaining the routine in the children's services. The dedication marked the official opening of the cottages, with a census of 46 children.

Research in Child Neurology

The week of October 18 saw the initiation in New York City of a far-reaching program of research in child neurology, made possible by a large grant from the Friedsam Foundation. Announcement of the new project was made recently by Dr. Bernard Sachs, its director. The project will explore the whole field of problems relating to the functioning of the child's nervous mechanisms, from their

beginnings in the prenatal state up to the period of adolescence. It will center around three major divisions: (1) organic functional disease of the nervous system in children; (2) neuroses and psychoses in early life; and (3) social, personality, and home problems. It will be national and international in scope, and will consist essentially of the provision of grants and scholarships to research workers all over the world. The council supervising the project is made up of three neuropsychiatrists, in addition to Dr. Sachs, three pediatricians, one orthopedist, and two laymen. Working with the council is an advisory committee composed of twelve eminent American and three European neurologists.

The program, Dr. Sachs explained, is independent and separate from a similar program started two years ago under his direction, through a grant of $100,000 from the Friedsam Foundation, at the New York Neurological Institute. While the actual sum of the new grant was not revealed, Dr. Sachs asserted it was "much larger" than the grant two years ago. The announcement describes the new undertaking as follow.:

> "With a grant from the Friedsam Foundation, a special council has been formed to stimulate research in child neurology and allied fields, so that physicians and other scientists may contribute to the thorough investigation of the many problems bearing upon the care and cure of those afflicted with any of the nervous and mental disorders from birth through adolescence.
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> "The research work is to be encouraged by stipend, scholarships or otherwise. It is to be national and international in scope. The results of the work will be recorded in volumes to be issued by the council from year to year. It is hoped that the first volume will appear in the winter of 1937.
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> "The trustees of the Friedsam Foundation, of which John S. Burke is president, believe that in helping to develop child-neurology research they are promoting the aims of the late Colonel Michael Friedsam, President of B. Altman & Company, who died April 7, 1931, and who was greatly interested in everything pertaining to child health and welfare.
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> "They regard child-neurology research as one of the major activities of the foundation and have authorized Dr. Sachs and the council to foster original investigations in that field to the greatest extent for the benefit of medical science and the community at large.
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> "The trustees find that neurology and psychiatry have important relations to the early training of children, to development of character, and to general medical and home conditions. They further agree with Dr. Sachs that the problems of child health and welfare may be properly considered to be closely allied fields for investigation.
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> "The work on child-neurology research at the Neurological Institute of New York, inaugurated by the Friedsam Foundation in 1934, has been so promising that the trustees have recognized the wisdom of extending the research beyond the limits of any one institution, city, or country."

New York City's Guidance Facilities Held Inadequate

New York City's program of care for children with behavior disorders and personality problems is short-sighted in failing to apply preventive measures because of expense, as the result is a much heavier cost in terms of delinquency, criminality, and adult mental illness, according to a statement made public on October 18 by the New York City Committee on Mental Hygiene of the State Charities Aid Association. The committee, of which Dr. George S. Stevenson is chairman, forms the Section on Mental Hygiene of the Welfare Council of New York City. The statement was based on a report by the Committee on Child Guidance, of which Dr. Ira S. Wile is chairman:

> "If there were as many cases annually of any disease as there are cases of children suffering from severe behavior disorders, various departments of the government would be demanding some mode of protection for the community against the disease processes and would be insisting upon more humane methods of dealing with children and adolescents suffering in that particular manner. The community should be as actively concerned with the prevention of mental disease as it is with the limitation of physical disorders.
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> "The organization of communal institutions in the interest of preventive medicine is long on theory and short on practice, particularly in definite programs to combat delinquency and crime. Delinquents and criminals are no more developed spontaneously than is typhoid fever or dementia praecox. When delinquent or criminal behavior appears, it is the final expression of causes that have been working for some period of time. All too frequently periodic symptoms, suggestive of impending catastrophe, become manifest in behavior that is definitely antisocial and asocial. Such expressions of disharmony are commonly called behavior problems, and the children are merely categorized as problem children. Just as a convulsion may initiate a pneumonia, or a delirium accompany high fever, so behavior problems may be the expression of definite disorders of function and indications of possibly more significant constitutional disorders. Society should be as much concerned with children presenting acute disorders of behavior, represented by antisocial symptoms, as it is in the more definitely physical manifestations of diseases that may be attributed to germ infection or toxic disorders.
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> "What facilities does New York City offer for the observation and constructive treatment and hospitalization of children whose illness is primarily represented by what is termed a behavior problem? Studies of the local situation reveal:
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> "Limited facilities for the study of behavior problems of children are to be found in seven hospitals in the city. These hospitals are: The Babies Hospital, Bellevue Hospital, Jewish Hospital of Brooklyn, Kings County Hospital, Long Island College Hospital, Neurological Institute, and New York State Psychiatric Institute. Some few private hospitals make special arrangements for the observation of children who are being treated in other divisions in the hospital or in the out-patient clinics of the hospital. However, the number of children who can be

taken for treatment in private hospitals is so slight as to be practically negligible.

"The Neurological Institute, a unit of the Columbia-Presbyterian Medical Center, accepts cases of all types of problematic behavior for study and treatment. There the child can be observed in a controlled situation and plans made for the best method of handling his problems. The child has the benefit of complete medical, psychological, and psychiatric observation, in which the causes of his difficulty that can be treated may be recognized and handled.

"The New York State Psychiatric Institute is a research institution which takes certain types of problem, depending on the research program that is in evidence at the time. The facilities for observation are similar to those at the Neurological Institute. There is a school program within the Psychiatric Institute, with a New York City public-school teacher assigned to this group of children. This furnishes a splendid opportunity for the trained observer to get an understanding of the behavior of the child and gives a background for recommendations for his care.

"Bellevue Hospital has full responsibility for real community service in this field. In the children's ward of the psychiatric unit, children up to fourteen years of age are accepted for observation. This unit serves as a clearing place for questionable cases that apply for admission to the state schools for mentally defective children as well as for study of behavior problems. Children placed in the observation ward at Bellevue have complete physical and psychological study. They attend school while in the hospital and have a recreational program. The stay of the children in the hospital is limited to a thirty-day period, at the end of which time recommendations of the staff are made to persons responsible for the child. Some children may need institutional care. Others, however, can be sent back to their homes with recommendations for treatment. Such service may clear up obscure causes of difficult behavior in children and give the cue for changing the behavior patterns. For example, the child that is troublesome at home and at school because he is jealous of a younger child, or because he needs some other forms of satisfaction than those which he has been receiving, may be returned to the community and the necessary changes be made in his situation, so that he becomes a truly social being with healthy satisfactions.

"Many children presenting early patterns of behavior difficulties could be studied and treated, changing the whole pattern of their lives. A program is short-sighted which avoids this kind of preventive care because of expense, yet has to carry a much heavier cost in terms of delinquency, criminality, and adult mental illness, which may be the result of behavior problems of children when they are not taken care of in the early stages.

"Only 60 children can be taken at Bellevue at one time. Many of these come from courts after they have become delinquent. A program of prevention would include facilities for hospital study and treatment of children before they get into real difficulties.

"There is also an uneven distribution of existing facilities in the five boroughs of New York, and this is another point of significance when the problem of meeting community needs is considered. The Neurological Institute, the Psychiatric Institute, and Bellevue Hospital—the hospitals

which are able to give service on a larger scale—are all located in Manhattan.

"Dr. S. S. Goldwater, Commissioner of Hospitals, understands the need for extending the mental-hygiene resources of the city hospitals and would undoubtedly carry out a program looking toward meeting the needs of each borough if funds were made available to his department in the budget.

"A comprehensive program of community planning for care and prevention of mental illness, the prevention of delinquency, and the treatment of behavior disorders in children would include greatly increased facilities for hospital observation and treatment of children with behavior problems before they get into the realm of delinquency and mental disease."

Symposium on New York City's Psychiatric Problems

That the municipal authorities are fully alive to the deficiencies in the provision of psychiatric facilities in New York City in proportion to the needs of its huge population is evident from a conference held at Bellevue Hospital on December 16 under the auspices of the Department of Hospitals, Division of Psychiatry, for the purpose of discussing the problem and developing plans to remedy the situation and provide more adequately for the present and future. It was the first of a series of meetings which the department plans to hold in an attempt to build up the city's mental-health resources and to promote coöperation between its psychiatric organization and the social, legal, and medical agencies of the state and city. About two hundred representatives of these professions attended.

Among those participating in the symposium were Judge Cornelius F. Collins, of the Court of General Sessions; Stanley P. Davies, General Director of the Charity Organization Society; Douglas P. Falconer, General Secretary of the Brooklyn Bureau of Charities; Dr. Foster Kennedy, of the Neurological Institute, representing the New York County Medical Society; Dr. Samuel W. Hamilton, of The National Committee for Mental Hygiene; Dr. Karl M. Bowman, Director, Division of Psychiatry, Department of Hospitals; and Dr. S. S. Goldwater, Commissioner of Hospitals, who presided.

One of the major obstacles to better psychiatric care, according to Mr. Davies, is the legal definition of insanity embodied in the existing commitment laws, which condition the procedures under which the mentally ill may be placed under medical care. He characterized as "antediluvian" the concept of mental disease underlying the present laws, and urged the importance of educating public opinion to bring about such changes in the laws as will give psychiatry "its proper authority" to define medically the point at which the mentally ill must be placed under institutional treatment. "We question the legal

concept of insanity which often imposes a long period of suffering on both the patient and his family," said Mr. Davies, "because no action can be taken until there seems to be legal justification for commitment."

Mr. Davies stressed the need for better clinical facilities for psychiatric diagnosis and treatment, which he said are now deplorably inadequate, and asked for closer coördination of social agencies and psychiatric clinics so that psychiatric advice, when social service is indicated, can be better utilized than it is at the present time. This was especially important, he pointed out, in the matter of follow-up treatment, since social service was a vital factor in conserving the benefits of hospitalization and promoting convalescence and often obviated the necessity of readmission to hospitals. The lack of such service makes it impossible to use the social resources of the community to the best advantage, and the social costs of inadequate psychiatric facilities far outweigh the expense of adequate facilities, he added.

Dr. Goldwater expressed the hope that the need of improved psychiatric and social services would be impressed upon the budget authorities, and that the medical boards of the various general hospitals of the city would similarly see the need of having one or more psychiatrists on their staffs. Mr. Falconer showed how insufficient the existing services are, and how unevenly distributed, by pointing out that the Borough of Brooklyn, with 1,000,000 more population than Manhattan, had only 161.5 hours of psychiatric-clinic service weekly, whereas Manhattan had 1,035 hours weekly of such service. Dr. Goldwater reported that a new mental-hygiene clinic was recently established in Brooklyn, to supplement the one at Bellevue Hospital, and that similar clinics were being planned for the boroughs of Queens and the Bronx.

Indicating the magnitude of the city's mental-health problem, Dr. Bowman said that 25,000 psychiatric cases had been admitted to city institutions in 1936. The care of the feebleminded, he said, presented an especially difficult problem, and he urged the erection of a new institution to relieve the overcrowding in existing state schools for the mentally deficient. He also reported that the Department of Hospitals has requested appropriations for the construction of a new psychiatric building in Brooklyn to replace the old structure now in use at the Kings County Hospital. Considerable progress has been made, he said, toward completing the equipment of the new psychiatric building at Bellevue Hospital, the various features of which he described.

Dr. Hamilton reviewed the situation in terms of the state hospitals serving the Metropolitan area. There are over 40,000 mental patients from New York City in the state hospitals, and these make up two-thirds of the total population in those hospitals. The expectancy of mental disease in New York City, he said, is one in 18, compared with one in 22 for the whole state. He intimated that these figures were a "reflection" on metropolitan life, though it was not certain that the incidence of mental disorders, as contrasted with the incidence of hospitalization, is noticeably on the increase. If there be an increase, he said, it is largely in the old-age groups, which have shown a markedly higher rate of hospital admissions in recent years. Since medical science has increased the expectation of life and the average age of the population is increasing, "we must expect more brain impairment in the later life decades." He said that the standards of the mental hospitals serving New York City were high and that "the treatment given our patients is excellent, so far as the size of our vast agglomerate hospitals permits, though we cannot say that they have as many doctors as could usefully be employed." The problem of alcoholism and its mental complications is most inadequately handled, he added, and while Bellevue Hospital has done excellent work in this field, the need for better institutional arrangements is most pressing. With regard to the future, he concluded, the state and city must bestir themselves to provide for the progressive increase in mental patients and to meet the growing demand of the community that a high grade of care and treatment shall be available for all types and degrees of mental illness.

Dr. Kennedy referred to dementia praecox and manic-depressive insanity as "two of the greatest scourges of civilization," and emphasized the importance of research and study, as so little is known concerning the nature and causes of these disorders. Much more must be done to implement psychiatry with the tools of modern medical science before we can expect advances in this field comparable to other branches of medicine. Commenting on the "uncertain attitude" of the law in its dealings with abnormal persons whose behavior is anti-social, Dr. Kennedy said it should be possible to obtain the same coöperation from the law in this respect as doctors have secured in connection with the control of communicable diseases and other problems of public health, so that the mentally ill may be under the jurisdiction, not of the law, but of the health authorities.

Judge Collins held that the fault is not so much in the commitment laws, which he said were adequately framed, as with the way they work out in practice. The trouble arises from the "human

equation" in the relations between the courts and professional workers, and from the difficulties inherent in the lack of adequate facilities and personnel and proper working arrangements.

Radio Forum on Child Development

Radio, with its plethora of "educational" programs, suffers, like literature, from the blight of overproduction. Unfortunately, listeners have not the benefit of a service akin to that provided by book reviewers, librarians, and bibliographers to guide them through the maze of talks, dialogues, dramatizations, and what not presented on the air by the growing multitude of those who are the counterparts of the vast army of authors, magazine writers, and publicists. Blindly we experiment with one or another of the features listed in the radio timetables, or we tune in on a program some radio addict among our friends may have recommended or that is brought to our attention by an organization in whose work we are interested, and occasionally we do happen upon something that sounds worth listening to.

One such program that has recently come to our attention is the Radio Forum, *On Growth and Development of the Child,* conducted under the joint auspices of The National Congress of Parents and Teachers, The American Academy of Pediatrics, and The National Broadcasting Company. This program is being broadcast over WJZ, NBC Blue Network, each Wednesday at 4 to 4:30 P.M., Eastern Standard Time, and will run through the winter and spring, up to May 19. It has the advantage not only of being built around an interesting and important subject, but it is also scientifically and technically sound, as attested by the list of topics presented and the distinguished roster of contributors to the program. And because it is on a national hookup we are glad to bring it to the attention of our readers.

Among the broadcasts with a mental-hygiene angle the following are scheduled: January 13, *Our Glands,* by R. G. Hoskins, Research Associate in Physiology, Harvard Medical School; February 3, *Heredity or Environment,* by E. C. MacDowell, Carnegie Institution of Washington; February 10, *How the Mind Grows in Infancy,* by Arnold Gesell, Director, Clinic of Child Development, Yale University; February 17, *How Children's Minds Grow,* by Walter R. Miles, Professor of Psychology, Institute of Human Relations, Yale University; March 3, *Emotional Development in Children,* by John E. Anderson, Director, Institute of Child Welfare, University of Minnesota; March 10, *The Connection Between Mind and Body Growth,* by Bert I. Beverly, Assistant Professor of Pediatrics, Rush Medical College; March 17, *Fitting the Course of Study to the*

Child's Mental Development, by Carleton Washburne, Superintendent Public Schools, Winnetka, Ill.; March 24, *Education and Mental Growth,* by Frank N. Freeman, Professor of Educational Psychology, University of Chicago. A complete list of the talks may be obtained from the National Congress of Parents and Teachers, 1201 Sixteenth Street, Northwest, Washington, D. C.

Fourth European Mental-Hygiene Reunion

Representatives of national mental-hygiene organizations in ten European countries met in London on October 5–6 for the fourth European Mental Hygiene Reunion held under the auspices of the National Council of Mental Hygiene of Great Britain. His Royal Highness, the Duke of Kent, President of the British organization, officially opened the conference, which devoted its discussions to two main topics—namely, mental hygiene and the nurse, and mental hygiene and the school. The speakers included Dr. Hans Roemer and Professor R. Sommer, of Germany; Dr. Viktor Wigert, of Sweden; Dr. Heinrich Kogerer, of Austria; Dr. J. R. Rees and Miss E. L. Macauley, of England; Dr. A. Soininen, of Finland; Dr. W. Morgenthaler, of Switzerland; Dr. Hans Evensen, of Norway; Professor Vermeylen, of Belgium; Professor K. H. Bouman, of Holland; and Dr. Georges Heuyer, of France. The following resolution was adopted at the close of the conference:

> "The Congress recommends that in each nation the administrative body charged with settling the methods of selecting abnormal school children and devising the timetables and curricula for normal scholars should include a psychiatrist duly elected by the mental-hygiene association of that nation."

State Society News

Connecticut

The Connecticut Society for Mental Hygiene announces the appointment of Dr. George K. Pratt as its medical director, to succeed Dr. E. Van Norman Emery, who resigned, after six years of service in that post, to become Professor of Social Psychiatry at Washington University, St. Louis, Missouri.

The Connecticut Society has been fortunate in the high caliber of the men chosen to direct its activities from its establishment as the first mental-hygiene society nearly thirty years ago, and we congratulate the society on the maintenance of its sound traditions and leadership in an ever-widening field of opportunity and service. Dr.

Pratt's many New York friends wish him the greatest success in his new position, for which his exceptional training and experience so peculiarly fit him.

Following his resignation as Assistant Medical Director of The National Committee for Mental Hygiene, which he served with distinction for eight years during the period of its greatest growth, Dr. Pratt entered into the private practice of psychiatry and established connections with a number of community agencies and clinics, including the New York Committee on Mental Hygiene of the State Charities Aid Association; St. Christopher's School, Dobbs Ferry, New York; the Bridgeport Society for Mental Hygiene; and the Child Guidance Advisory Service of Stamford. Prior to his affiliation with the National Committee, he was medical director of the Massachusetts Society for Mental Hygiene.

With his assumption of the directorship of the Connecticut Society, Dr. Pratt shifts the center of his professional activities to New Haven, where, in addition to his organization duties, he will also serve as assistant clinical professor of psychiatry and mental hygiene at Yale University. His new connections will provide larger opportunities than ever for the conduct of those educational activities in which he has distinguished himself for many years as a lecturer and writer.

Kansas

The September *Bulletin* of the Kansas Mental Hygiene Society, received after the last issue of this journal went to press, reports its annual meeting, held in Topeka on May 8–9, as "the most successful annual convention" the society has ever had. An interesting and instructive program, and the large attendance, swelled by the presence of many teachers from the Topeka school system, combined to provide "great impetus" to the state's mental-health activities, the *Bulletin* states. The speakers included Dr. Leo H. Bartmeier, of Detroit; Dr. Mandel Sherman, of the University of Chicago; Dr. Paul E. Kubitschek, of St. Louis; Dr. Herbert Shuey, of Topeka; and Dr. Bert A. Nash, of Lawrence, Kansas.

Dr. Bartmeier sounded a warning against "child guidance" that fosters a dependency in children suggestive of the "regimentation" to which children have been subjected in totalitarian states. "Child guidance," said Dr. Bartmeier, "is essentially an educational activity, one that attempts to include all educational instruments, such as the family, the school, church, courts of law, and medical clinics, in a coöperative program calculated to achieve a degree of uniformity within limits which will stabilize our social structure and reduce the

cost of misfits in our civilization. Where child-guidance organizations have not attempted to encompass too much, either too many problems or too large a sphere, they have achieved a monumental success. While our avowed aim has been the liberation of the child from doctrines and tenets and compulsions which were imposed on us, we must frankly ask ourselves whether we are not substituting newer doctrines of our own and, at the same time, making the child so dependent that it might be questionable as to whether he could maintain an independent position."

Dr. Sherman advised parents to guard against "overprotecting" their offspring against reality and competition. The adolescent, he said, tries to free himself from control by his parents, and in the process is likely to do many things which adults consider childish or eccentric. "In practicing our mental hygiene we must understand these unusual ways of behaving as attempts to be grown up and to be important. As a matter of fact, we adults also do many queer things in order to be recognized as important individuals. . . . It is extremely important that realistic values be developed in children so that they can carry over into adulthood attitudes which do not involve them in emotional conflict." Dr. Sherman stressed two essentials of "a careful program of mental hygiene"—employment of positive methods in maintaining the mental health of the child or adult, and avoidance of constant criticism or nagging. He opposed corporal and other forms of punishment which do more to show the inadequacy of parents in dealing with the child than they do to correct the child's behavior.

Dr. Kubitschek showed how individuals differ in natural endowments and abilities. Besides physical and mental characteristics, he regarded the factor of emotional or nervous stability as "a third major component which, in my opinion, is also to a considerable degree an inherited character and varies as much in uniformity as do the physical and intellectual factors." This factor, he said, is not susceptible of objective demonstration, but he believed "it not only exists, but plays an extremely important rôle in determining the effectiveness with which the individual is able to use his other capacities."

Wisconsin

The Wisconsin Society for Mental Hygiene held its annual open meeting in Milwaukee on September 26, in conjunction with the Wisconsin Conference of Social Work. The speakers were Dr. H. Douglas Singer, of Chicago, and Dr. A. I. Rosenberger, of Milwaukee. Dr. Esther H. de Weerdt, of Beloit, presided.

Dr. Rosenberger discussed the work and aims of mental-hygiene organizations from the standpoint of the general practitioner, and urged greater coöperation from the medical profession. "The doctors of our community typify the conservatism of Milwaukee County," he said. "We are slow to accept new forms of treatment. I fear that even to-day many of our doctors have been held back in enthusiastically supporting the mental-hygiene program because of a mistaken suspicion of the true merits of the movement. In times past our profession has freely given its services to any program that had to do with the prevention and cure of disease. To-day we are confronted with a new program of a new era. What can we do to increase the emotional and mental efficiency of our fellowmen? My plea is for greater coöperation between such a useful organization as the Wisconsin Society for Mental Hygiene and the Milwaukee County Medical Society."

Dr. Singer outlined some of the medico-legal problems involved in the commitment of the mentally sick and, stressing the need for better facilities for the observation of persons who might be suffering from mental disorder, advised the society to interest the larger communities in making observation wards available in their general hospitals. He also urged the society to work for more progressive mental-hygiene legislation, and for the elimination of politics from the management of state hospitals, especially in connection with the selection of personnel.

Various committee reports reflected the growth of the society's activities in several directions, and announcements were made of a coming series of public lectures, and a special program of popular radio talks to be given under the joint sponsorship of the Wisconsin Society for Mental Hygiene and the County Medical Society. At the annual meeting of the board of directors held at the same time, the following officers of the society were elected: *President,* Dr. Esther H. de Weerdt; *Vice-President,* Dr. H. W. Powers; Secretary, Mrs. C. B. Clark; *Treasurer,* Mrs. J. S. Walbridge, Jr.

National Crime Prevention Institute

"Recognizing that crime is related to social and personal conditions involving a vast range of knowledge and technique that is too extensive to be included in one program, and that many national agencies are already at work in most of the ranges of this expanse, the Crime Prevention Institute sees as its chief possible contribution the coördinating of existing activities and the filling of gaps." With this preamble, a new organization known as the National Crime Prevention Institute, Inc., and composed of representatives of the legal

and medical professions, psychiatry, psychology, education, social work, and other students of the crime problem, introduced itself to the public in a statement recently issued announcing its scope and objectives.

The purposes of the institute are tentatively stated as follows: (1) To act as a clearing house of crime-prevention information; (2) to provide a machinery for conference and voluntary coöperation looking toward the coördination of crime-prevention activities in city, state, and nation; (3) to develop and carry on crime-prevention programs in areas of this field not now occupied by other agencies until such time as other agencies are ready to carry on such functions; and (4) to promote public education for crime control through use of recognized channels of publicity.

The organization was formed, according to the announcement, in response to the need for "a cosmopolitan organization that can secure a perspective on these varied activities and use its efforts to bring them into closer functioning." The institute is thus not just another agency to combat the forces of criminality and lawlessness, but a new and much needed mechanism designed for the very practical purpose of uniting in a synthesis of correlated aims and efforts, through closer working relationships, the many agencies already engaged in this large and complex field. Visualizing its potential usefulness, the institute sees itself conducting exploratory or demonstration studies in conjunction with the appropriate specific agencies; building community programs through drawing together the various special interests; discovering needs for which no agencies now exist; developing these new fields and organizing agencies to care for them; and arranging periodic reviews of the activities of specific national agencies, either directly or through the supervision of joint enterprises, and thereby bringing the separate agencies into unison.

The statement then illustrates some of the concrete activities and possibilities to which the institute proposes to address its efforts, to wit: It can bring the public schools to give more serious attention and service to children in danger of becoming delinquent, through further development of the responsibilities of the teacher, through the organization of special activities and services of the school staff outside the classroom, and through similar development of community services, conditions, and responsibilities. It can concern itself with the informing of parents; it can bring about a preventive function on the part of police; it can develop in theological circles a better appreciation and technique for meeting problems with which they are faced daily; it can support legislation designed to prevent crime, and enlist the assistance of the press, the cinema, and the

radio; and it can bring national agencies in other fields to a more serious consideration of the problems of rural communities and small cities.

The officers of the National Crime Prevention Institute, which has established offices at 425 Fourth Avenue, New York City, are as follows: *President,* Professor Sheldon Glueck; *Vice-Presidents,* Dr. Vernon C. Branham, Judge Jeanette G. Brill, Judge Cornelius F. Collins, and Hon. Austin H. MacCormick; *Treasurer,* Dean George W. Kirchwey; *Secretary,* Dr. Frederic M. Thrasher; *Chairman, Executive Committee,* Professor Harvey W. Zorbaugh.

"March of Time" Film No. 6

There is such a dearth of educational material of the visual type in the field of mental hygiene that we hasten to bring to the attention of mental-hygiene workers interested in behavior disorders of children an excellent film produced recently by "March of Time" and dealing with the prevention of juvenile delinquency. It was taken at the last annual conference of the National Probation Association, which has arranged for its distribution to non-commercial educational organizations at cost. It is a sound film, of eight minutes' duration, and depicts with astonishing realism the close relation between juvenile delinquency and community conditions. The coöperative action now being organized in many cities by social and character-building agencies to meet the problem is sympathetically portrayed. It is an intensely dramatic story of boy gangsters in a great city and the mobilization of community resources to prevent crime, and should prove a popular educational and entertainment feature for many types of organizations. The film is available in two sizes: 16 mm. sound film for $12.00, and 35 mm. sound film for $23.80, both on the safety-film stock required for portable projectors. (Sound films cannot be shown on silent-film projectors, and silent prints are not available.) Orders for the film should be sent with check (payable to "March of Time") to the National Probation Association, 50 West 50th Street, New York City. Ask for "March of Time" Film No. 6, juvenile-delinquency portion.

London Agency Requests Data on Human Genetics

The Bureau of Human Heredity of London is soliciting the aid and coöperation of American students and workers in human genetics in its efforts to collect as complete a record as possible of current information in this field. The bureau is directed by a council representing medical and scientific bodies in Great Britain, and is affiliated with the International Human Heredity Committee, which promotes col-

laboration in all areas where research in genetics is under way. R. Ruggles Gates is the chairman of the bureau, and the executive committee includes R. A. Fisher, J. B. S. Haldane, C. B. S. Hodson, and other eminent geneticists.

The council would be grateful to receive all available material from institutions and individuals on the transmission of human traits, whatever these may be. Pedigrees are particularly desired, and twin studies and statistical researches are also relevant. Data should be given with all available details in regard to source, diagnostic symtoms, and the name and address of the person or persons who vouch for their accuracy. All such details will be regarded as confidential. Research workers desiring to retain the sole right of publication (or copyright) are asked to send with their material a statement to this effect.

The council would also welcome reprints of published work, as well as any pedigrees that authors may not have been able to reproduce in detail when their material was published. It is the object of the council that such records, by being included in its clearing house, should not be lost. Later it proposes to analyze this material and arrange for the redistribution of the information available. Announcements in regard to the services undertaken by the bureau will be published from time to time. Those who wish a copy of the Standard International Pedigree Symbols may obtain one from the Council. Communications should be addressed to the Bureau of Human Heredity, 115 Gower Street, London, W.C. 1, England.

CURRENT BIBLIOGRAPHY *

Compiled by

FREDERICK W. BROWN

Abbott, Grace. The juvenile courts. Survey, 72:131–33, May 1936.

Ackerman, Nathan W., M.D. and Menninger, C. F., M.D. Treatment techniques for mental retardation in a school for personality disorders in children. American journal of orthopsychiatry, 6:294–312, April 1936.

Ackerson, Luton. On evaluating the relative importance or "seriousness" of various behavior problems in children. Journal of juvenile research, 20:114–23, July 1936.

Adamson, Elizabeth I., M.D. A common factor relating to five hundred psychiatric patients. Medical woman's journal, 43: 243–46, September 1936.

Adrian, Edgar Douglas, M.D. The nervous system. Science, 84:275–78, September 25, 1936.

Alper, Benedict S., and Lodgen, George E. The delinquent child in Pennsylvania courts. Mental hygiene, 20: 598–604, October 1936.

Anderson, Harold H. Conflicts in personality development. Mental hygiene: 20:605–13, October 1936.

Anderson, Harold H. Growing in responsibility. Childhood education, 13:5–7, September 1936.

Anderson, John E. Bringing up twins. Parents' magazine, 11:26, 94–97, October 1936.

Bender, Lauretta, M.D., and Woltman, Adolf G. The use of puppet shows as a psychotherapeutic method for behavior problems in children. American Journal of orthopsychiatry, 6:341–54, July 1936.

Berry, R. J. A., M.D. Brain size and mentality. British medical journal, No. 3940, 62–65, July 11, 1936.

Billings, Edward G., M.D. Teaching psychiatry in the medical school general hospital. Journal of the American medical association, 107: 35–39, August 29, 1936.

Blake, Dorothy. Fitting the child to the home. National parent-teacher magazine, 31: 12–13, 28–29, September 1936.

Blanton, Smiley, M.D., and Zerler, Mary Louise. Helping the child who stutters. National parent-teacher magazine, 31:14–15, 22, October 1936.

Bogen, Eugene F., M.D. Effects of long hospitalization on psychotic patients. Mental hygiene, 20:566–78, October 1936.

Boyd, Neva L. Play as a means of social adjustment. Journal of health and physical education, 7:410–12, 465–6, September 1936.

Bradley, Charles, M.D. A children's hospital for neurological and behavior disorders. Journal of the American medical association, 107: 650–53, August 29, 1936.

Brenneman, Laura Jane. Shall we have state medicine? Sociology and social research, 21:54–62, September 1936.

Brown, Felix, B.M. The bodily complaint: a study of hypochondriasis. Journal of mental science (London), 82:295–359, July 1936.

Brown, Fred. The problem of nervousness and its objective verification in children. Journal of abnormal and social psychology, 31:194–207, July-September 1936.

Bruno, Frank J. Social security and social work. Family, 17:219–26, November 1936.

Cane, Florence. The gifted child in art. Journal of educational sociology, 10:67–73, October 1936.

Cannon, Walter B., M.D. The rôle of emotion in disease. Diplomate, 8: 191–201, October 1936. (Reprinted from the Annals of internal medicine, May 1936.)

Cassels, W. H., M.D. The psychological distinction between the various types of schizophrenia. Canadian medical association journal (Toronto), 35: 411–17, October 1936.

* This bibliography is uncritical and does not include articles of a technical or clinical nature.

Cattell, Raymond B. Is national intelligence declining? Eugenics review (London), 28:181–203, October 1936.

Chappell, M. N., M.D. and Stevenson, T. Irving, M.D. Group psychological training in some organic conditions. Mental hygiene, 20:588–97, October 1936.

Charles Sherman Little. Mental hygiene, 20:646–47, October 1936.

Cheney, Clarence O., M.D. Past, present and future problems in psychiatry. American journal of psychiatry, 93:1–15, July 1936.

Cobb, Stanley, M.D., and Finesinger, Jacob E., M.D. The psychiatric unit at the Massachusetts general hospital. Monthly bulletin (Massachusetts society for mental hygiene), 15:1–3, September-October 1936.

Craft, J. H. The effects of sterilization. Journal of heredity, 27:379–387, October 1936.

Craft, J. H. The South Dakota mental survey as a basis for social control of the mentally defective. Mental hygiene, 20:630–45, October 1936.

Culpin, Millais, M.D. The history of psychology in medicine. Proceedings of the royal society of medicine (London), 29:1569–76, October 1936.

Davis, Minnie Lee. Diagnostic cards for kindergarten and first grade. Childhood education, 13:32–35, September 1936.

Day, Florence R. Social case work and social adjustment. Family, 17:197–204, October 1936.

Dayton, Neil A., M.D. Marriage and mental disease. New England journal of medicine, 215:153–55, July 29, 1936.

Deardorff, Neva R. Planning the welfare program. Survey, 72:263–65, September 1936.

Dick, E. R. Methods of teaching psychiatric nursing and mental hygiene. Canadian public health journal, 27:385–90, August 1936.

Doll, Edgar A. Preliminary standardization of the Vineland social maturity scale. American journal of orthopsychiatry, 6:283–93, April 1936.

Ebaugh, Franklin G., M.D. The present status of psychiatry in medical education. Southern medical journal, 29:784–88, August 1936.

Emery, E. Van Norman, M.D. First interviews, as an experiment in human relations. American journal of orthopsychiatry, 6:268–82, April 1936.

Farnell, Frederic J., M.D. Child growth and emancipation. Archives of pediatrics, 53:630–34, September 1936.

Feder, Leah. Early interviews as a basis for treatment plans. Family, 17:236–40, November 1936.

Fisher, Dorothy Canfield. What price popularity? Parents' magazine, 11:20–21, 86–88, October 1936.

Fisher, Motier, and Fisher, Raymond. The lonely child. Hygeia, 14:921-24, October 1936.

Ford, Mary E. N. An evaluation of a parent education program. Family, 17:230–36, November 1936.

Gates, Arthur I., and Bond, Guy L. Failure in reading and social maladjustment. Journal of the National education association 25:205–6, October 1936.

Gegenheimer, Ruth A. The mental defective and his leisure. Mental health bulletin (Pennsylvania state department of welfare), 14:9–14, October 15, 1936.

Giberson, Lydia G., M. D. Psychiatry in industry. Personnel journal, 15:91–95, September 1936.

Gillespie, R. D., M.D. Psychological factors in asthma. British medical journal, No. 3938:1285–89, June 27, 1936.

Greenbie, Marjorie Barstow. Some children can't read. Parents' magazine, 11:30–31, 88–91, October 1936.

Grierson, Hugh A., M.B. Memory and its disorders in relation to crime. Journal of mental science (London), 82:360–70, July 1936.

Groves, Ernest R. Let's face the problem of cheating. National parent-teacher magazine, 31:6–7, 24, October 1936.

Gruenberg, Sidonie Matsner. What does the home expect of the school? Child study, 14:3–5, October 1936.

Hart, Henry Harper. The bogey of abnormality. Medical record, 144:311–13, October 7, 1936.

Hegge, Thorleif G., and Ward, Lewis B. Remedial reading methods. American journal of orthopsychiatry, 6:421–30, July 1936.

Hicks, Robert Alan. Hysteria—the hidden monster. Hygeia, 14:882–86, October 1936.

Hoffman, Martin H., M.D., and Altshuler, Ira M., M.D. The attendant's part in mental patient care. Hospital management, 42:26, 45, September 1936.

Hollingworth, Leta S. The Terman classes at public school 500. Journal of educational sociology, 10:86–90, October 1936.

Hopkins, Sir Frederick Gowland. The influence of chemical thought on biology. Science, 84:255–60, September 18, 1936.

House, Roy Temple. The technique of sleeping. Hygeia, 14:893–95, October 1936.

Hurlock, Elizabeth B. Intelligence tests for babies. Parents' magazine, 11:37, 56, 58, October 1936.

Hyman, Harold Thomas, M.D. The value of psychoanalysis as a therapeutic procedure. Journal of the American medical association, 107: 326–29, August 1, 1936.

Jackson, J. Allen, M.D. An outline of the relation of the mental hospital to the education of the nurse. Mental health bulletin (Pennsylvania state department of welfare), 14: 3–5, October 15, 1936.

Jelliffe, Smith Ely, M.D. Children's problems: a generalized approach. American journal of orthopsychiatry, 6:406–11, July 1936.

Johnson, Eleanor Hope. Objective tests, including the Bernreuter personality inventory, as constructive elements in a counseling technique. American journal of orthopsychiatry, 6:431–36, July 1936.

Jones, Ernest. The future of psychoanalysis. International journal of psychoanalysis, 17:269–77, July 1936.

Kardiner, Abram. The rôle of economic security in the adaptation of the individual. Family, 17:187–97, October 1936.

Karlsberg, I. J., M.D. The problem of sexual sterilization of the mentally diseased and defective. Medical times, 64:415–18, October 1936.

Keliher, Alice V. So they're going to school. National parent-teacher magazine, 31:6–7, 34–37, September 1936.

Kelso, Robert W. Tomorrow's social work training. Survey, 72:259–62, September 1926.

Kennedy, Foster, M.D., and Wolf, Alexander, M.D. The relationships of intellect to speech defect in aphasic patients. Journal of nervous and mental disease, 84: 125–45, August 1936. (to be continued)

Krout, Maurice H. Emotional factors in the etiology of stammering. Journal of abnormal and social psychology, 31:174–81, July–September 1936.

Lenroot, Katherine F. Boys out of institutions. Survey, 72:139–40, May 1936.

LeSourd, Howard M. Friendliness and character. National parent-teacher magazine, 31:11–12, November 1936.

Levy, David M., M.D. Hostility patterns in sibling rivalry experiments. American journal of orthopsychiatry. 6:183–257, April 1936.

Liddell, H. S. Pavlov's contribution to psychology. Psychological bulletin, 33:583–90, October 1936.

Liss, Edward, M.D. Roots of school problems. Child study, 14:8–11, October 1936.

Livingood, Fred G. Directed extracurricular activities and adjustment. Mental hygiene, 20:614–23, October 1936.

Malzberg, Benjamin. Mental disease among native and foreign-born whites in New York State. American journal of psychiatry, 93:127–37, July 1936.

Markey, O.B., M.D. and Noble, Helen. An evaluation of the masculinity factor in boarding home situations. American journal of orthopsychiatry, 6:258–67, April 1936.

Mateer, Florence. Clinical problems of bright children. Journal of educational sociology, 10:91–99, October 1936.

McCrory, Mae. Mental hygiene applied to reading. Childhood education, 13:17–20, September 1936.

Medical jurisprudence of crime—a symposium. Current legal thought, 3: 1–93, October 1936.

Crime and personality, by Eugene Kahn, M.D.

Crime and the individual, by William Healy, M.D.

Medical aspects of crime, by William Norwood East, M.D.

Crime and the social reaction of right and wrong, by Trigant Burrow, M.D.

The place of psychiatry in the criminal law, by Winfred Overholser, M.D.

The person versus the act in criminology, by E. H. Sutherland.

The problem of mental disorder in crime, by L. A. Tulin.

Modern tendencies in habitual criminal legislation, by J. A. Royce McCuaig.

Functions of psychiatry in a training school for juvenile delinquents, by Clarence O. Cheney, M.D.

Social psychiatric aspects of the minor delinquent, by Abraham Myerson, M.D.

An intensive psychiatric study of prisoners—the receiving routine in the classification clinic, Elmira reformatory, by James L. McCartney, M.D.

Considerations basic to a new penal code, by Alfred L. Gausewitz.

Michaels, Joseph J., M.D. and Schilling, Margaret E. An attempt to determine the degree of antisocial behavior in psychopathic personalities and its correlation with the Porteus maze and the Binet-Simon tests. American journal of orthopsychiatry, 6:397–405, July 1936.

Oberndorf, C. P., M.D. Sigmund Freud—his work and influence. American journal of psychiatry, 93: 21–28, July 1936.

Ödegaard, Örnulv, M.D. Emigration and mental health. Mental hygiene, 20:546–53, October 1936.

Odlum, Doris M. Alcoholism and drug addiction in relation to mental health. British journal of inebriety, 34:55–65, October 1936.

Olson, Willard C. The diagnosis of oral habits in children from the condition of the hands. Journal of abnormal and social psychology, 31: 182–89, July–September 1936.

Orgel, Samuel Z., M.D. The meaning of children's habits. Archives of pediatrics, 53:463–75, July 1936.

Page, Marjorie L. Are leaders made or born? Parents' magazine, 11: 27, 81–83, October 1936.

Patey, Henry C. The significance of psychological tests to psychiatric diagnosis. Delaware state medical journal, 8:126–31, June 1936.

Popenoe, Paul, M.D. Twins and criminals. Journal of heredity, 27:388–390, October 1936.

Potter, Ellen C., M.D. Good will toward mental hospitals. Modern hospital, 47:56–59, September 1936.

Proceedings of the second annual conference of the California state coordinating council. Journal of juvenile reseach, 20:124–47, July 1936.

1. Unadjusted youth, by Vierling Kersey.
2. Where prisoners come from, by Sanford Bates.
3. The status of the coördinating council program in California, by Norman Fenton.
4. Panel discussion of questions raised by coördinating councils, by Mrs. Elta S. Pfister, Robert McKibben, and John R. Lyons.

Rees, J. R., M.D. Neurosis, its effect on employer and employee. Industrial welfare and personnel management (London), 18:29–31, October 1936.

Reynolds, Bertha C. Applying what we know in mental hygiene. Public health nursing, 28:646–49, October 1936.

Reznikoff, Leon, and Glass, Lillian. Social psychiatry and physical disability. Journal of educational sociology, 10:108–16, October 1936.

Rich, Gilbert J., M.D. Contributions of psychology to mental hygiene. Mental hygiene, 20:554–65, October 1936.

Ringer, Paul H., M.D. What constitutes an interesting case? New York state journal of medicine, 36: 1243–48, September 1, 1936.

Roback, A. A. Fifty years of the dissociation theory. Journal of abnormal and social psychology, 31: 131–37, July–September 1936.

Rockwell, Olive T. Psychiatric-social treatment in the mental hygiene clinic. Delaware state journal of medicine, 8:131–37, June 1936.

Rosenzweig, Saul, M.D. Some implicit common factors in diverse methods of orthopsychiatry. American journal of orthopsychiatry, 6:412–15, July 1936.

Rowntree, Jennie I. The teacher as coördinator. Childhood education, 13:21–23, September 1936.

Russell, G. Oscar. Speech clinics: an unfilled need. Modern hospital, 47: 87–89, October 1936.

Schaus, Hazel S. "All the others do it." National parent-teacher magazine, 31:8–9, 26–27, September 1936.

Schmenkenberg, Arthur J., M.D. Minor neuropsychiatry. Medical times, 64: 351–55, September 1936.

Selling, Lowell S., M.D. A new profession: psychiatric criminology. American journal of orthopsychiatry, 6:437–39, July 1936.

Sloane, Paul, M.D. The use of a consultation method in case work therapy. American journal of orthopsychiatry, 6:355–61, July 1936.

Stamp, Sir Josiah. The impact of science upon society. Science, 84: 235–239, September 11, 1936.

Stanton, Hazel M. The gifted child in music. Journal of educational sociology, 10:74–85, October 1936.

Studebaker, John W. Parents, children and schools. National parent-teacher magazine, 31:8–9, 27, November 1936.

Sutton, Lucy Porter, M.D. Shortening an attack of St. Vitus dance. Parents' magazine, 11:34, 92–93, October 1936.

Tallman, Frank F., M.D. The organization of state-hospital child-guidance clinics. Mental hygiene, 20: 579–87, October 1936.

Tarumianz, M. A., M.D. Psychiatric implications of endocrine disturbances. Delaware state medical journal, 8:93–98, June 1936.

Thompson, Charles B., M.D. Some new aspects of the psychiatric approach to crime. Mental hygiene, 20:529–545, October 1936.

Throop, George R. Sound mind in sound body. Journal of health and physical education, 7:417–18, 461, September 1936.

Tillotson, Kenneth J., M.D. Psychobiology in general medicine. New medical record, 144:325–26, October 146–49, July 29, 1936.

Trapp, Carl E. Notes on the psychiatrical knowledge of the classical era. Medical record, 144:325–26, October 7, 1936.

Treadway, Walter L., M.D. Comments on mental health administration. American journal of psychiatry, 93: 177–89, July 1936.

Treadway, Walter L., M.D. The significance and content of mental health administration. Southern medical journal, 29:788–91, August 1936.

Vincent, Lee. A square deal in the schoolroom. Hygeia, 14:916–20, 956–57, October 1936.

Vincent, Lee. Youth needs to believe in itself. Hygeia, 14:776–79, 855–856, September 1936.

Wells, F. L., and Hylan, N. W. Psychometric practice in adults of superior intelligence. American journal of orthopsychiatry, 6:362–75, July 1936.

White, Arthur W., M.D. Abdomen conscious. Southern medical journal, 29:803–06, August 1936.

Wholey, Cornelius C., M.D. The rôle of psychiatry in the penitentiary; a study of 200 psychotic prisoners. Pennsylvania medical journal, 39: 952–58, September 1936.

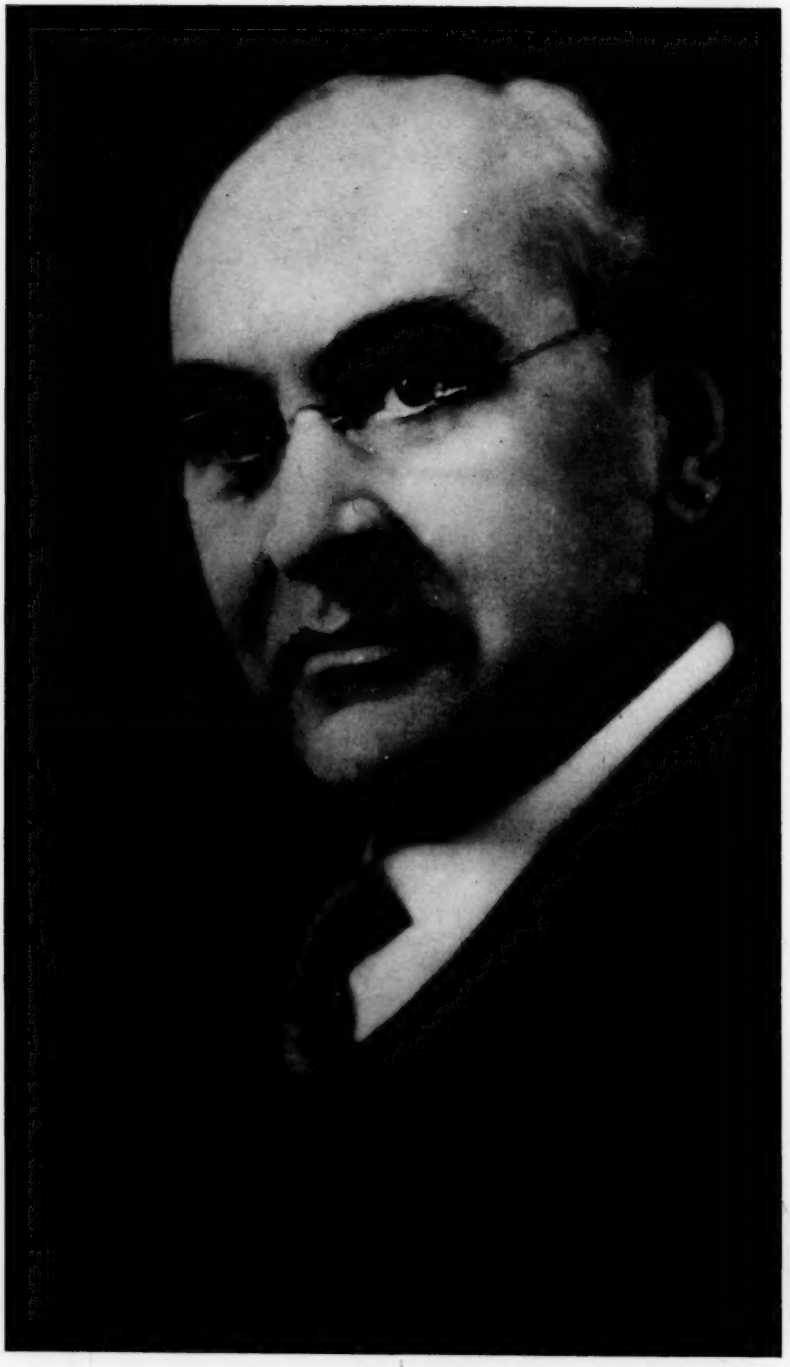
Wile, Ira S., M.D. The rôle of forgettery in education. American journal of orthopsychiatry, 6:376–396, July 1936.

Williams, E. Y., M.D. Unguarded discussions at the bedside. Mental hygiene, 20:624–29, October 1936.

Williams, James N., M.D. The function of the state bureau of mental hygiene. Virginia medical monthly, 63:395–97, October 1936.

Wolf, Anna W. M. New thoughts on spanking. Parents' magazine, 11: 28–29, 100, October 1936.

Zorbaugh, Harvey W., and Boardman, Rhea K. Salvaging our gifted children. Journal of educational sociology, 10:101–108, October 1936.



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1870–1937